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FRONTLINE NURSING LEADERS AND STAFF RETENTION IN AN ACUTE CARE COMMUNITY HOSPITAL

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FRONTLINE NURSING LEADERS AND STAFF RETENTION IN AN ACUTE CARE COMMUNITY HOSPITAL

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

by

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I can do everything through him who strengthens me.

~Philippians 4:13 (NIV)

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Abstract

FRONTLINE NURSING LEADERS AND STAFF RETENTION IN AN ACUTE CARE COMMUNITY HOSPITAL

Beth Lindsey Torres, Ph.D., RN, CCRN

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2009

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The current and projected nursing shortage makes it imperative for healthcare organizations to examine factors that promote staff retention. Previous studies identify nursing leadership as a key component influencing staff retention and turnover. This study supplements these studies by identifying key behaviors and attitudes of frontline nursing leaders that influence staff retention. Using a grounded theory qualitative approach, the researcher interviewed 19 frontline nursing leaders in an acute care community hospital. The researcher also explored the extent to which nursing leaders felt current leadership education and training programs support their practices that promote staff retention. The goal of the study was to create a theory or model of nursing leadership and staff retention grounded in the data.

Five major themes emerged from the interview data analysis process using grounded theory strategies. These themes include organizational culture and policies, nursing leaders training and development, behaviors and attitudes, employee factors, and turnover. The researcher interpreted the data within a systems theory conceptual framework. Using this framework aided the researcher in creating a model of frontline nursing leaders and staff retention. This model illustrates the inter-relationship of the five major themes from a systems perspective.

The usefulness of the data collected in this study is predicated on three major domains: competency identification; human resource management and development; and education. Competencies form the foundation for the education and practice of frontline nursing leaders (Barker et al., 2006). These role-specific, evidenced-based expectations should be clearly delineated in competency-based job descriptions, which in turn merge into performance evaluations. Explicitly defined competencies provide a conceptual framework for collegiate and hospital-based education and training programs to train current and future frontline nursing leaders.

Chapter 1 Introduction

Introduction

This study examined frontline nursing leadership behaviors and attitudes influencing staff retention. This first chapter provides an overview of the study purpose and design. Chapter One describes background information supporting the study, the problem statement with a discussion of the professional significance of the problem, an overview of relevant nursing leadership literature, definitions of key terms, an overview of the methodology, and delimitations of the study. The chapter concludes with a brief description of the organization of the dissertation.

Background Information

Healthcare institutions currently face a critical nursing workforce shortage. The average age of a practicing registered nurse (RN) is 46.8 years old with nearly 26 percent of nurses over the age of 54 (Health Resources and Services Administration [HRSA], 2004). By 2010, projections forecast that approximately 40 percent of the U.S. nursing workforce will be over 50 years of age (Robert Wood Johnson Foundation [RWJF], 2006). These statistics suggest that large percentage of nurses will retire in the next decade. Factors contributing to the nursing shortage include an aging population of baby

boomers requiring health care services, fewer young people entering the workforce, more job options for women, an insufficient number of minorities entering the nursing profession, and a physically and mentally challenging work environment leading to job dissatisfaction (Heller, Oros, & Durney-Crowley, 2000; Kimball & O'Neil, 2002; NAS, 2005). The national turnover rate within hospitals for registered nurses averages 21% (Force, 2005). Sources estimate critical care nurse turnover at 26% (Strachota, Normandin, O'Brien, Clary, & Krukow, 2003). Replacing a registered nurse working on a medical/surgical unit costs an estimated $92,000, while the cost for replacing a registered nurse for intensive care reaches up to $145,000 (RWJF, 2006). The top two reasons RNs identified for changing employment pertain to job dissatisfaction and growth opportunities (Herrin & Spears, 2007).

Research in healthcare shows a strong relationship between job satisfaction and nursing retention (Force, 2005; Lynn & Redman, 2005; McNeese-Smith, 1997; Strachota et al, 2003). Many factors contribute to job dissatisfaction and whether a nurse will choose to stay. These factors include staffing and scheduling, group cohesion, work intensity, lack of recognition and support, workforce compensation, work culture, and stress (Brewer, Zayas, Kahn, & Sienkiewicz, 2006; Force, 2005; Larkin, 2007; McNeese-Smith, 1997). In addition to these factors, studies show that the leadership behaviors of nurse managers influence job satisfaction and, consequently, retention (RWJF, 2006). How staff perceive nurse-managers and how they are treated and mentored is critical to retention efforts (Contino, 2004). As competition for human capital intensifies, hospitals

must closely monitor the impact nursing leaders have on staff job satisfaction and thus on nursing retention.

In addition to the shortage of staff nurses, there exists an impending shortage of qualified, competent nursing leaders upon which minimal attention has been focused (Sherman & Bishop, 2007). In the study conducted by Sellegren (2006), 80% of the 77 participating nursing leaders were between the age of 41 and 60 years old. The average age of the nursing leader in other studies reviewed was 46.7 (Laschinger, 2007; Lindholm & Uden, 2001; Sherman & Bishop, 2007). The fact that the average age of the nursing leaders mirrors the staff nurses indicates similar issues with impending retirement. Unless organizations have competent nursing leaders waiting in the pipeline and plan for succession management, they will find themselves with a dearth of nursing leaders to replace those exiting the workforce. Strengthening current and future nursing leaders' knowledge and skills will ultimately lead to improved professional and patient outcomes (Sherman & Bishop, 2007) as well as improve nursing retention.

Statement of the Problem

A multitude of factors contributes to the nursing shortage. Alleviating this shortage involves targeting recruitment and retention. The literature suggests focusing on retention as an advantage point. Retention poses a multifaceted problem in which nursing leadership surfaces as a key issue. Frontline nursing leaders directly oversee the largest employment population in a healthcare facility and maintain responsibility and accountability for the operations of individual patient care areas. Nursing leaders, by their behaviors and attitudes, can influence staff nursing turnover and intent to stay. However,

limited formal studies exist on these frontline nursing leaders and the behaviors and attitudes that contribute to retention. Therefore, this study explored the perceptions of frontline nursing leaders in an acute care hospital of behaviors and attitudes that contribute to retention of staff nurses. In addition to this central focus, this study sought to answer the additional question, "To what extent do nursing leaders feel current leadership education and training programs support their practices that promote staff retention?"

Rationale and Significance of the Study

This study has two primary goals for how the data can be used. The first goal pertains to human resource factors, which include hiring and evaluating frontline nursing leaders. It has been said, "People do not leave an organization; they leave their manager." Given the correlation of leadership and staff turnover, having the right person in the right job/position becomes imperative. Knowledge of the competencies and behaviors for frontline nursing leaders that contribute to staff retention, and the personal attributes that complement these competencies, will better aid senior administrators in the hiring process. Hiring the "wrong" person can have serious ramifications—operationally and financially—for the organization. Incorporation of these competencies into the evaluation process allows for ongoing assessment of current skills, knowledge, and abilities and provides a mechanism for developmental planning to address gaps in these elements.

In addition to using this knowledge for hiring and evaluation purposes, the information gained from this study could guide leadership training provided by hospitals, universities, and leadership institutes. With more nursing schools adding a leadership

track in their Master of Science in Nursing (MSN) degree program, this information can help guide course and curriculum development. Just as the field of nursing has moved to evidence-based practice for clinical practice, it also needs to use evidence-based practice in training current and future nursing leaders.

According to a survey published by the American Hospital Association in 2001, 75% of the responding hospitals reported difficulty recruiting registered nurses. The panel predicts a shortage of 434,000 RNs by 2020. The critical nursing shortage makes each nurse a valuable commodity. High turnover, especially when experienced nurses leave, affects patient outcomes and jeopardizes patient safety (Anthony, et al., 2005; Bondas, 2006; Wong & Cummings, 2007). The Joint Commission (TJC) increased their emphasis on patient safety for the 2008 standards. TJC has 16 specific patient safety goals listed for 2008. “The purpose of the Joint Commission’s National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems” (www.jointcommission.org). TJC cites *leadership* as the third leading root cause of sentinel events for 2006. TJC defines a sentinel event as an “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof” (ibid). Given this emphasis on patient safety, healthcare organizations must make retention of experienced nursing staff a priority. Experienced and knowledgeable bedside nurses form the foundation for quality patient care (Force, 2005). Low staff turnover promotes patient safety by keeping experienced nurses at the bedside

and serves as an excellent recruiting point. In order to retain experienced nurses, organizations must examine factors contributing to nursing turnover.

The top two reasons for RNs changing employment pertain to job dissatisfaction and growth opportunities (Herrin & Spears, 2007). Job dissatisfaction correlates strongly with intent to leave a unit and turnover (Strachota et al, 2003). Although nurses leave a unit for multiple reasons, dissatisfaction or conflict with the immediate supervisor serves as a major contributor to overall job dissatisfaction (Leveck & Jones, 1996; McVicar, 2003; Strachota et al, 2003). This study seeks to discover the perceptions frontline nursing leaders have of what behaviors and attitudes influence staff retention.

Overview of the Literature Review

The review of literature for nursing leadership covers a broad spectrum of topics. For the purposes of this study, the literature review focuses on specific key concepts of nursing leadership. These concepts include the nursing shortage; factors influencing RN job satisfaction, retention, and turnover; patient safety and outcomes as they pertain to turnover and nursing leadership; leadership competencies and behaviors; pathways to nursing leadership positions; and education/training requirements. Covered in this section will be a brief overview of these domains. Chapter Two provides a detailed discussion of the topics mentioned in this section.

The nursing literature well documents the nursing shortage. The issues of decreasing supply and increasing demand for RNs permeates nursing journals as organizations, academic and professional, look for ways in which to recruit qualified applicants into the field. Faced with fiscal and physical limitations, in 2006, Schools of

Nursing (SON) nationwide denied admission to over 42,000 qualified applicants to baccalaureate and graduate programs secondary to insufficient numbers of faculty, classrooms, and clinical sites (AACN, 2006). In the 2006-2007 academic year, the application acceptance rate reached 41.3 % (AACN, 2006). This situation will intensify as one in four nursing faculty become eligible to retire in the next five years (Malone, 2003). The average age of doctoral-prepared nursing faculty is 55.7 years, and most nursing faculty retire around age 62 years (AACN, 2003). Until organizations address and ameliorate these problems, recruitment into the nursing profession will remain a factor contributing to the overall nursing shortage.

Nurses graduating from SON find themselves with the unique opportunity of being selective in where they choose to work. Healthcare organizations find themselves in steep competition to recruit these new graduates (Herrin & Spears, 2007). In addition to overcoming the challenge of recruiting new graduates to replace retiring nurses, healthcare organizations must focus on retaining qualified, experienced nurses and decreasing turnover in this same population of employees. The key to stabilization of the nursing workforce hinges on retention (Corning, 2002).

Nursing retention presents as a multifaceted issue with by many variables. The research on nursing retention speaks to the vital role of the frontline nursing leader as essential in retaining nurses at the bedside (Buckingham & Coffman, 1999; Contino, 2004; Force, 2005; Herrin & Spears, 2007). While an effective solution to the nursing shortage includes nursing leadership at all levels of the organization, the frontline nursing leader contributes the greatest influence on a nurse's organizational commitment and

intent to stay. McNeese-Smith (1997) found a direct relationship between organizational commitment and nursing management behaviors. Behaviors contributing to organizational commitment (retention) include empowering staff, visionary leadership, encouraging professional development, recognizing staff accomplishments, shared governance in problem solving, and individual respect and consideration. Training nursing leaders to actualize these behaviors can contribute to increased staff retention.

Retaining nurses promotes operational and fiscal stability. Stable workforces reduce the direct and indirect expenses associated with turnover. Direct expenses are associated with recruiting and hiring replacement nurses. Replacing a nurse costs an organization almost double the nurse's annual salary (RWJF, 2006). Costs associated with replacing a nurse include temporarily filling the position with per diem or traveling nurses at high hourly wages, lost productivity from inability to fill the position, advertising and interviewing costs, and once hired orientation and training expenses. In addition to incurring direct expenses, organizations also encounter indirect costs. Inability to fill a position results in higher nurse-patient ratios, which correlate with job dissatisfaction and increased likelihood of an adverse patient outcome (RWJF, 2006; Strachota et al, 2003).

The above literature review highlights the pivotal role of the frontline nursing leader in retaining competent staff and the impact of turnover financially and operationally on the organization, as well as the negative impact of turnover on patient outcomes. Hiring and training competent nursing leaders has the potential for profound impact across all aspects of the organization and care delivery. Despite this knowledge,

most of the studies on nursing leadership competencies and behaviors, education, and training have either focused on the executive level of nursing leadership (AONE, 2005; Byers, 2000, 2001; Carroll, 2005; Dunham-Taylor & Klafebu, 1995; Vance & Larson, 2002) or were mixed and/or not specific to frontline nursing leaders (Brewer et al, 2006; Force, 2005; Krejci, 1997; Leveck & Jones, 1996; McVicar, 2003; Scoble & Russell, 2003; Upienieks, 2002; Wong & Cummings, 2007). A limited number of studies related specifically to frontline nursing leadership competencies, behaviors, education, and training exist (Anthony et al, 2005; Gould, 2001; Mathena, 2002; Sherman & Bishop, 2007; Strochota et al, 2003). Of these studies, fewer still collected data from frontline nursing leaders on the competencies, behaviors, and attitudes that promote staff retention. Herein lays the need for additional research on this vital group of nursing leaders. Understanding the lived experiences of frontline nursing leaders can further add to the body of knowledge regarding competencies, behaviors, and attitudes and the education and training necessary to assist these individuals in a role crucial to nursing retention.

Definitions

The following terms will be used as descriptors for this study.

Frontline Nursing Leaders: This study defines frontline nursing leaders as persons having 24/7 direct supervision and budgetary control over nursing units providing patient care. Other common terms for this position include Nursing Director, Head Nurse, Nurse Manager, and Unit Coordinator. Not included in this group of leaders are persons at the senior administrative level (Chief Nurse Executives, Chief Nursing Officer, and Vice President of Nursing) or those responsible only for a specific shift

(Assistant Head Nurses, Clinical Unit Coordinator, and charge nurses). Frontline nursing leaders represent a mid-level of nursing leadership between the senior administrative level and the shift leadership level.

Manager: Manager is defined as the person who accomplishes the business of an organization through other people.

Leader: A leader is defined as "an individual within a group or an organization who wields the most influence over others" (Greenberg & Baron, 2003, p. 471). A leader promotes an organization's mission, whereas a manager maintains responsibility for implementation of the mission.

Leadership: Leadership is defined as "the process through which an individual attempts to intentionally influence another individual or a group to accomplish a goal" (Shortell & Kaluzny, 2000, as cited in Wong & Cummings, 2007, p. 509).

Constant Comparative Analysis: Constant comparative analysis is a qualitative technique for examining data in which the researcher identifies distinctive categories from the data collected. These categories are flexible and subject to modification as the researcher collects, compares, and contrasts additional data to previously collected data. This inductive process allows common themes to emerge from the data (McMillan & Schumacher, 2006).

Competency: Competency is defined as "the ability to perform a specific task in a manner that yields desirable outcomes" (Kak, Burkhalter, & Cooper, 2001, p. 3). Competencies include the skills, knowledge, and abilities necessary to perform a role while meeting a safe level of practice.

Behaviors: Behaviors encompass the manner in which the individual acts and responds to a stimulus. Behaviors denote the person's theory-in-use in which he/she manifests competencies.

Attributes: Attributes denote the inherent qualities or characteristics a person exhibits.

Retention: Retention represents the ability to maintain people in their current position.

Turnover: Turnover denotes employees ending employment, either on a specific unit or with the organization, both voluntary and involuntary.

Turnover Rate: Turnover rate represents the number of people required to replace those leaving.

Organizational Commitment: Greenberg and Baron (2003) define *organizational commitment* as "the extent to which an individual identifies and is involved with his or her organization and/or is unwilling to leave it" (p. 668).

Organizational Culture: Organizational culture encompasses the values, beliefs, attitudes, and behavioral norms and expectations within an organization (Greenberg & Baron, 2003).

Education: Education refers to the academic preparation an individual received (as opposed to training received in a nonacademic setting). For instance, a nurse may receive academic education at a diploma, an associate degree, or bachelor degree level in order to prepare for Board Certification to become a registered nurse.

Training: Training refers to the continuing education an individual received to prepare for a higher level of performance beyond academic education. For instance, an RN attends classes to learn how to interview potential employees.

Overview of the Methodology

The researcher designed the study for qualitative data collection and analysis using grounded theory. This methodology was chosen to increase knowledge of the views, values, and beliefs of frontline nursing leaders. The researcher sought to gain understanding of their lived experiences (Orb, Eisenhauer, & Wynaden, 2001). Qualitative researchers are "intrigued by the complexity of social interactions expressed in daily life and by the meanings that the participants themselves attribute to these interactions" (Marshall & Rossman, 2006, p. 2). Following a phenomenological perspective, the researcher sought to understand the frontline nursing leader's viewpoint and meanings of these lived experiences.

Data sources for this study included the perceptions of frontline nursing leaders in a large suburban acute care hospital in central Virginia. The research site encompassed a large two-campus healthcare corporation, which employs approximately 22 frontline nursing leaders overseeing inpatient units. The eligibility requirement for participation in the study was 6 months of employment at the study site in a frontline nursing leadership position. Recruitment of participants was done at the direction and assistance of the Chief Nursing Officer (CNO), who verbalized full support of the study. Participation in the study was voluntary and offered no extrinsic incentives. Participants could withdraw from the study at any point.

All potential participants received written information about the study. The nursing leaders interviewed received written and verbal information about the study and were asked to provide verbal and written consent. The researcher assured confidentiality as part of the recruitment and informed consent process. The organization and nursing leaders are not identified by name. The researcher assigned all leaders a generic pseudonym of “NL” followed by an identification number. The use of pseudonyms helps protect participants’ identities (Orb et al, 2001), both in the dissertation and in future publications. All references to the organization, specific units, or names in direct quotes and documents included in this dissertation were removed. In addition to protecting the identity of the site and participants, university and hospital institutional review board (IRB) approval was obtained prior to data collection.

Data collection to learn the nursing leaders’ perceptions entailed a single researcher conducting face-to-face, semistructured interviews. An interview guide provided the interviewer with a list of questions and topics for exploration. The literature review and research questions formed the basis for the interview questions. The CNO received a copy of the interview guide and had the opportunity to make modifications prior to the commencement of data collection. Once the participants were confirmed, background information for the study was sent electronically to each interviewee. The researcher conducted interviews on-site in the nursing leaders’ natural environment. Formal and informal interviews, a focus group, and document review provided valuable data to attain common patterns.

The researcher used inductive data analysis to analyze data collected. This process entailed the use of several techniques to help organize, categorize, and identify emerging themes in the data. All interviews were audio recorded with participant permission and transcribed verbatim. Interviewees reviewed and validated the transcripts and had the opportunity to make modifications. Data reduction consisted of grouping and summarizing the data into key words and phrases, major categories, and themes. Using constant comparative analysis, the data were compared within and between the participants, looking for common and differing characteristics and themes (Glauser & Strauss, 1967). Using grounded theory helps to generate a theory explaining an action, interaction, or process (McCaslin & Scott, 2003). From the data categories, a model of nursing leadership competencies, behaviors, and attitudes that influence nursing retention emerged.

Delimitations of the Study

Several delimitations exist for this study. The first delimitation pertains to generalizeability. This study was conducted with participants from one organization, and the results may not apply to organizations with varying missions and visions for healthcare as well as dissimilar organizational structure. For instance, since the study was conducted in a for-profit community healthcare facility, the results may be different if replicated in an academic medical facility or a nonprofit community facility.

A second delimitation involves the narrowness of focus. This study targeted the frontline nursing leader competencies, behaviors, and attitudes that the leaders felt

influence staff retention. While other competencies for this position emerged from the literature review, the focus remained on those related to staff retention.

A final delimitation pertains to the researcher's employment at the research site. Because the researcher works at the research site and is known by the participants, conducting qualitative research in this site might raise ethical concerns. Although the researcher may obtain accurate results because of knowing the organization and having the trust of the participants, the potential exists for participants to feel obligated to participate or they may limit the information they provide (Orb et al, 2001). Conducting research in one's own area has the potential to affect validity, reliability, and meaningfulness of the data (Orb et al, 2001). To address these issues, the researcher ensured confidentiality, provided informed consent, and requested an outside person, not affiliated with the study site or the university, contact participants to validate their voluntary participation and that they gave information without constraint. Chapter 3, Methodology, addresses these ethical issues in more detail.

Conclusion

The critical nursing shortage mandates that healthcare organizations explore opportunities for improving nursing recruitment and retention. Current literature supports the premise that nursing leaders play a critical role in nursing job satisfaction, which correlates with retention and intent to stay. The high cost of nursing turnover and the adverse effect on patient outcomes provide the impetus for these healthcare organizations to hire qualified individuals into nursing leadership positions. Knowing the competencies, behaviors, and attitudes of frontline nursing leaders that influence staff retention can

provide guidance in the hiring and training process, thus ultimately influencing patient outcomes in addition to contributing to operational and fiscal stability of the organization.

Chapter 1 provided an overview of the study. Background information laid the foundation for factors influencing nursing leadership. Research questions and the rationale for the study were presented next, followed by an overview of pertinent nursing leadership literature. Definitions of key terms were provided to enhance clarity in subsequent chapters. The methodology overview described an emergent design. Lastly, delimitations were identified.

Chapter 2 contains a comprehensive review of literature on nursing leadership as it pertains to retention and turnover, leadership competencies, education, and training for nursing leaders. Chapter 3 outlines the study design for collecting qualitative data. Chapter 3 discusses the use of informed consent and expounds on strategies to increase reliability and validity of the data. Data results are presented in Chapter 4. The final chapter, Chapter 5, summarizes the findings and provides a discussion of the findings.

Chapter 2 Review Of The Literature

Introduction

Chapter 1 provided a general overview of the study. Included in Chapter 1 was a brief overview of literature reviewed. Chapter 2 expands on this review. The intent of this chapter is not to provide an extensive review of all literature relating to nursing leadership. Instead, the purpose is to elucidate on the literature supporting the decisions regarding the research question of the study. Chapter 2 describes the major concepts supporting the research questions. Before delving into the literature, the next section provides a brief summary of the process for conducting the literature review.

Methodology for Conducting the Literature Review

The literature review was conducted using electronic databases such as MEDLINE, CINAHL, PubMed, and Health Reference Center (Gale). These databases were broadly searched for peer-reviewed studies and publications on factors relating to nursing leadership competencies. Publications reviewed included research articles as well as publications on theory, concepts, and opinions of current nursing and business leaders. In addition to the databases listed, key websites were searched for relevant reports. These websites included American Organization of Nurse Executives (www.aone.org),

American Association of Colleges of Nursing (www.aacn.nche.edu), Robert Wood Johnson Foundation (www.rwjf.org), and the U.S. Government Accountability Office (www.gao.gov).

Combinations of the following keywords were used to search the databases: leadership, nursing, and competency. The key word "competency" served as a proxy for nursing leadership behaviors. The search of CINAHL with "leadership" and "nursing" yielded over 800 refereed, research articles published 1996-2007. From the variety of databases used, citations were chosen based on relevance to the study questions. Each citation was screened and categorized as primary research or nonresearch. Systematic literature reviews were coded in the research category since they were based on primary research. Research articles were further categorized by publication, methodology and participants (level of nursing leader) (see Table 1). Of the numerous studies and articles found pertaining to nursing and leadership, only a limited number related specifically to frontline nursing leadership competencies. For this reason, the search was expanded to include studies pertaining to nursing executives or those that included mixed levels of participation. In the studies reviewed, the authors collected data pertaining to nursing leadership competencies from a variety of health care providers: nurse executives, frontline nursing leaders, physicians, respiratory therapists, and staff nurses. Four of the primary studies reviewed (Anthony et al., 2005; Gould, 2001; Strachota, 2003; & Sullivan et al., 2003) collected data on frontline nursing leaders and retaining staff.

Table 1. Summary of Literature Review by Methodology and Level of Nursing Leadership, n=21a

Level of Leadership	Methodology			
	Literature Review (n=4)	Quantitative (n=3)	Qualitative (n=11)	Mixed Method (n=2)
Frontline Nursing Leaders	1	2	5[b]	1
Nurse Executive	1		2	1
Mixed or not specific	2	1	4	

[a]One study did not describe the research methodology other than to describe tools used to collect data.
[b]One study conducted on Nurse Executives collected the data from staff nurses versus the nursing leaders.

In addition to primary studies, the literature review included published reports, documents, and articles pertaining to nursing leadership competencies. Only one of these documents specifically addressed frontline nursing leaders (Contino, 2007). These publications were analyzed and coded by topic and content along with the primary studies. Content analysis occurred for nursing leadership skills, knowledge, attributes, job satisfaction, retention/turnover, leadership styles, and education/training preparation (see Table 2).

Table 2. Frequency of Topics Found in the Literature Review, n=28

Topic	# Times Found
Job Satisfaction	12
Retention	11
Turnover	8
Leadership Style	17
Why Become NL	2
Outcomes	3
Education/Training	8
SKA	28

Note: References marked with a single asterisk indicate studies included in the systematic literature review.

The data collected for the skills, knowledge, and abilities are summarized in Table 3. Table 4 lists the attributes of effective leaders frequently found in the literature. The information contained in Tables 3 and 4 will be discussed later in this chapter. Information synthesized from these studies and articles guided the development of the research questions. The limited number of primary research on frontline leaders illustrates the need for additional research focusing on this specific group and the competencies they demonstrate which contribute to nursing retention.

Importance of Study Question

Despite the surge in nursing leadership studies earlier in this decade, few studies have been conducted in recent years on frontline nursing leaders. Most of the studies reviewed focused on the nurse executive position or were not specific to the frontline nursing leader. Moreover, although many studies correlate nursing leaders with nursing turnover and retention, the problem persists. The literature reveals that most nursing leaders are unprepared for the rigors of the position (Bondas, 2006; Kerfoot, 2007; Sherman et al., 2007), thus affecting their level of effectiveness. Given this fact, it becomes incumbent upon academia and hospital-based training programs to develop evidence-based leadership development programs specific to the level of nursing leadership most in demand. Few nursing leaders become nursing executives, yet much of the literature and training programs have historically focused predominantly on this level of nursing leadership for training and development. Larkin (2007) speaks to the paucity of research “on how to retain the skills and expertise of experienced bedside nurses” (p. 162).

Table 3. Competencies for Nursing Leaders

Professional Domain	
Relationship with Staff	**Personal Mastery**
Communication	Visioning
Coach, Mentor, Role model	Decision making
Staff Development	Professional Development
Team Building	Analytic; Systems thinking
Change Agent	Clinical Competency
Empowerment	Time Management
Social awareness	Ethics

Table 3 (continued)

Administrative Domain			
Manager Role	**Human Resource Management**	**Fiscal**	**Outcomes**
Staffing	Retaining Staff	Budget	Patient Focus
Safety	Hiring; Recruiting	Balance Cost & Quality	Research; Evidence-based Practices
Technology; Information Management	Cultural Competence	Payroll	Quality Management Process Improvement
Political Savvy	Recognition; Praise		Staff Satisfaction
Regulations	Performance Feedback		Risk Management
Problem solve; Negotiation	Discipline		MD satisfaction
Strategic Planning			

Note: References marked with a single asterisk indicate studies included in the systematic literature review. References marked with two asterisks indicate additional resources used to compile data in Tables 3 and 4.

Table 4. Attributes of Effective Nursing Leaders

Flexible	Trust	Honesty/Integrity
Empathy/Caring	Respect	Fair/Consistent
Passionate/Committed	Motivated	Creative/Innovative

Note: References marked with a single asterisk indicate studies included in the systematic literature review. References marked with two asterisks indicate additional resources used to compile data in Tables 3 and 4.

These issues form the foundation for this study to explore the central question of what competencies a frontline nursing leader should possess to effectively promote staff retention.

The literature review undergirding this study focuses on the following areas related to the research question: What is leadership? In what ways does nursing leadership influence job satisfaction, thus influencing retention/turnover rates? This section will also describe the literature on the influence of leadership style on job satisfaction. Next, the literature review explores the skills, knowledge, abilities for nursing leadership positions. The final portion pertaining to the study questions addresses education and training for nursing leaders, including pathways to nursing leadership.

What is Leadership?

In order to understand the competencies of effective nursing leaders, the distinction between a manager and a leader requires differentiation, as well as a brief explanation of the importance of shifting from a management to a leadership perspective. Although leadership and management may coexist, they are two distinct concepts

(Manion, 2005). Manion draws on the work of Bennis (1989) when comparing and contrasting a manager and a leader.

A manager accomplishes the business of an organization through other people. Managers tend to be more task-oriented and occupy positions of formal authority. A manager accomplishes the goals of an organization through planning, organizing, and controlling human and material resources (Sofarelli & Brown, 1998). A manager focuses on efficiency and doing things right. Policies and procedures provide structure for performance. Productivity and performance become key objectives and measurements of success. Organizational goals take precedent over relationships. In accomplishing organizational goals, the manager attempts to answer the questions of *How? When? Where? Who?* Effective managers understand what needs to be done and how to accomplish it through available resources. For this reason, health care organizations tend to promote nurses with exceptional clinical and organizational skills to management positions.

In contrast to a manager, a leader is defined as an individual within a group or an organization who possesses the ability to influence others (Barker, Sullivan, & Emery, 2006; Greenberg & Baron, 2003; Manion, 2005). This definition implies that people wish to follow this individual. Leadership integrates a reciprocal process between those who lead and those who choose to follow (Carroll, 2005). Jooste (2004) defines *effective leadership* as “enabling ordinary people to produce extraordinary things in the face of challenge and change and to constantly turn in superior performance to the long-term benefit of all concerned” (p.217). She describes the difference between management and

leadership as “legitimate power and control vs. empowerment and change” (p. 218). What distinguishes a leader from a manager?

The conceptual framework of a leader differs from that of a manager. While a manager’s priority hinges on doing things right, a leader’s concern focuses on doing the right things to support organizational goals and values. A leader questions *Why?* If the answer does not support the mission of the organization or if there is a better way to accomplish something, decisions result in changes to processes and policies. Leaders exhibit openness to change and facilitate process improvement. A leader questions the purpose of an activity and explains the rationale to the followers, helping them to understand why they are asked to perform a specific task. Most importantly, a leader expresses and exhibits concern for the people who follow and concentrates on building relationships. This last characteristic distinguishes a leader from a manager and provides the foundation for the leadership role. Because of the relationship with subordinates, a leader creates a shared vision (Kouzes & Posner, 1995, 2007; Senge, 1990) and empowers employees to achieve the vision as a team. In this respect, a leader creates and promotes an organization’s mission and vision, whereas a manager maintains responsibility for implementation of the mission.

Manion (2005) identifies three major reasons for the shift from management to leadership: constant change; shifting paradigms; and survival. The dynamic and fluid nature of healthcare creates an environment of constant change. Leaders must display flexibility, creativity, and innovation to keep pace with regulatory requirements, societal changes (including changes in demographics of the workforce), and scientific/

technological changes. Manion indicates that the paradigms through which we view our world are in flux. In our global and mobile society, competition for workers and clients has expanded beyond the immediate vicinity. Leading between the paradigm shifts becomes essential for survival. An organization's effectiveness rests on its leaders. Effective leadership helps to keep organizations solvent during uncertain times.

This section of the literature review differentiated between a manager and a leader, emphasizing the centrality of relationships for leaders. A brief discussion of the paradigm shift from management to leadership followed. Organizational survival was one of three reasons for this shift. Leaders play a pivotal role in organizational survival. The next section of the literature review delves into the correlation between the nursing leader and job satisfaction.

Nursing Leaders and Employee Job Satisfaction

While this study focuses on frontline nursing leaders' competencies and staff retention, an understanding of the relationship between the nursing leader and the staff's perception of job satisfaction is warranted to understand what competencies a frontline leader should possess thereby heightening staff satisfaction with the workplace.

The literature reflects the strength and the magnitude of the influence of nursing leaders on staff job satisfaction. Of the 21 primary studies reviewed, 10 referenced this relationship. Vance and Larson (2002) compared leadership studies conducted between 1970-1999 for healthcare and businesses. During this timeframe, over one-third of the research in healthcare pertained to the influence of leadership on subordinate's job satisfaction, retention, and performance.

The literature identifies numerous factors influencing job satisfaction. These factors include staffing and scheduling, group cohesion, work intensity, lack of recognition and support, workforce compensation, work culture, and stress (Brewer, Zayas, Kahn, & Sienkiewicz, 2006; Force, 2005; Larkin, 2007; McNeese-Smith, 1997). Nurses rank stress as a primary reason for leaving their job (Brewer et al., 2006). In the literature review relating to nurses' perceptions of work stressors conducted by McVicar (2003) between 1985 and April 2003, 11 studies identified leadership and management issues as a work stressor.

The work of Upenieks (2002) corroborates the role of the nursing leaders in staffs' job satisfaction. Upenieks interviewed four nursing executive and twelve frontline nursing leaders with at least two years experience to ascertain the impact of organizational structure on leader effectiveness and success. Kanter's theory (1993) of organizational behavior formed the conceptual framework for this study. Kanter's theory is predicated on the premise that structural aspects of a job shape the leaders' effectiveness in the job performance. Nursing leaders possessing formal and informal power, along with access to information and resources, can then empower their clinical staff by sharing this power, thereby enhancing the nurses' effectiveness. Upenieks associated nursing leader effectiveness with staff job satisfaction.

Nursing staff job satisfaction correlates with positive leadership behaviors and leadership style (McNeese-Smith, 1999). Seven of the studies speaking to job satisfaction also discussed leadership styles. Upenieks (2002) indicates, "Empowerment is significantly related to organizational commitment, work satisfaction, and mangers'

leadership style" (p. 624). Nurses report lower levels of job satisfaction with controlling managers. Controlling managers most closely align with a transactional leadership style.

The work of James MacGregor Burns (1978) forms the foundation for current research and literature on transactional and transformational leadership. Transactional leaders practice contingent reward leadership in which they specify goals, expectations, and rewards (Avolio & Bass, 1998; Barling, Slater, Kelloway, 2000; Burns, 1978; Dunham-Taylor & Klafebu, 1995; Force, 2005; Sellgren et al., 2006; Vance & Larson, 2002). By operating in a management by exception modality, these leaders correct subordinates depending on the adequacy of their performance. Managers often exhibit transactional leadership through the creation and enforcement of structure, role expectations, and policies and procedures.

In comparison, transformational leaders consider others' needs over their own personal needs, demonstrate consistency between espoused beliefs and actual behaviors, do what's right, exhibit high standards of ethical and moral conduct, focus on continual improvement of themselves and others, and develop relationships with staff (Avolio & Bass, 1998; Dunham-Taylor & Klafebu, 1995; Force, 2005). Burns (1978), in his seminal work, states transformational leadership occurs "when one or more persons *engage* with others in such a way that leaders and followers raise one another to higher levels of motivation and morality" (p. 20). The transforming effect of this leadership style affects both the leader and the followers' behaviors and ethical aspirations. Transformational leaders are perceived by their followers as "possessing more charisma, providing more intellectual stimulation, and giving more individualized consideration" (Dunham-Taylor

& Klafebu, 1995, p. 69) as compared to transactional leaders. These characteristics of a transformational leader align with leaders exhibiting high levels of emotional intelligence.

Gardner and Stough (2002) found a strong relationship between transformational leadership and emotional intelligence in their study with 110 business leaders. “Leaders who use transformational behaviors motivate their employees to do more than is expected” (p. 74). They also found a positive relationship between contingent rewards (a component of transactional leadership) and emotional intelligence. This finding corroborates the earlier findings of Barling et al. (2000) in which they found a positive relationship between emotional intelligence and three aspects of transformational leadership (idealized influence, inspirational motivation, and individualized consideration) and contingent reward (an element of transactional leadership).

The nursing literature on leadership frequently ties elements of emotional intelligence (EI) to transformational leadership as a preferred leadership style. Contino (2004) defines EI as “the ability to mange one’s emotions while having awareness of the emotions of other” (p. 62). She goes on to say, “Emotional intelligence skills enhance leaders’ ability to create opportunity for their peers, employers, and customers through self-awareness and self-regulation” (p. 62). A key domain of emotional intelligence includes competencies related to social awareness and relationship management (Carroll, 2005). Social awareness involves the ability to reads others’ emotions and understand their perspective. The leader desires to put the needs of the individual before their own. Relationship management involves having a clearly articulated shared vision and the

ability to influence others through feedback and guidance. Leaders with strong relationship leadership skills know how to manage conflict and create collaboration for a common goal.

In addition to the above mentioned leadership skills stemming from EI and transformational leadership behaviors, Snow (2001) identifies the following benefits of EI:

- Improved performance of nursing personnel, leading to more satisfied patients, physician, and families;
- Improved retention of top talent;
- Improved teamwork;
- Increased motivation by team members;
- Enhanced innovation in the nursing group;
- Enhanced use of time and resources;
- Restored trust between nurses and their leaders (p. 443).

These benefits of emotional intelligence mirror those identified by Barling et al. (2000) for transformational leadership: enhanced subordinate satisfaction with leadership, increased trust in leadership, and increased organizational commitment.

The literature clearly shows the advantages of transformational leadership behaviors over transactional leadership behaviors. However, not all elements of transactional leadership should be discounted. Dunham-Taylor and Klafen's study (1995) suggests that effective leaders exhibit both transformational and transactional management styles. Because hospital units sometimes operate in "crisis mode," the more directive, authoritarian style associated with transactional leadership might be warranted during these times. As a primary leadership style, the facilitative and interpersonal

characteristics of transformational leadership and EI tend to be associated with higher staff satisfaction and with staff retention (Strachota et al., 2003).

This section began by differentiating between a manager and a leader and how the characteristics of the two influence leadership. The literature reviewed highlighted the relationship between nursing leaders and staff job satisfaction and how leadership style contributes to staff perception of job satisfaction. Descriptions of transactional and transformational leadership followed. The section concluded with a brief discussion about the association of transformational leadership and emotional intelligence (EI). The next portion of the literature review addresses the role nursing leaders play in staff organizational commitment as measured by turnover/retention ratios.

Nursing Leaders' Role in Staff Organizational Commitment

The previous two sections of this chapter addressed the role the nursing leader in staff job satisfaction. Job satisfaction is inherently a manifestation of organizational commitment as measured by turnover/retention ratios. This section explores the literature on why staff leave a job and factors influencing organizational commitment and thus retention.

Given the magnitude of the nursing shortage and the projected exodus of nurses retiring within the next decade, focus has turned to exploring factors influencing turnover and retention. The national average for turnover for a RN on a medical-surgical unit is 20% (Force, 2005). Within critical care, the average jumps to 26%. Chapter 1 discussed the expense of replacing nurses, both from a financial and an operational standpoint. The costs of experienced RNs leaving come through lost productivity, loss of expertise, and

the negative effect on patient care. It stands to reason that it is less expensive and disruptive to retain nurses than to replace them (Strachota et al., 2003). In order to promote retention, organizations must determine why employees leave, either a specific unit, or the organization.

Nurses leave a unit or organization for many reasons. These reasons relate to job satisfaction, supervision, work environment, and personal reasons (Strachota et al., 2003). The most common reason cited in the literature for leaving a position pertained to hours worked—long shifts, overtime, weekends, nights, and holidays. In the study by Strachota et al., "management not supportive" tied for the fourth most common reason along with unsatisfactory pay and benefits and inadequate staffing. From a survey done by the Advisory Board's Nurse Executive Center, Contino (2004) reports that 84% of the nurses surveyed (n=1600) considered leaving their jobs because of dissatisfaction with their direct nurse manager as compared to 43% of the nurses who were very satisfied with their manager who still considered leaving.

In order to retain nurses, organizations must examine their managers' behaviors and leadership styles to ascertain the influence on staff job satisfaction and desire to leave or stay with the organization. Conducting and critically analyzing employee job satisfaction surveys can provide organizations with knowledge regarding staff perceptions of the work place. Gallup has collected data for employers on employees for over 25 years now. Five factors emerged from their studies: work environment/procedures, immediate supervisor, team/co-workers, overall company/senior management, and individual commitment/service intention (Buckingham & Coffman,

1999). The immediate supervisor category addresses issues "relating to the behavior of the employees' immediate supervisor—issues such as selection, recognition, development, trust, understanding, and discipline" (p. 253). Of the 13 questions asked in the Gallup survey, five relate to factors influencing retention:

1. Do I know what is expected of me at work?
2. Do I have the materials and equipment I need to do my work right?
3. Do I have the opportunity to do what I do best every day?
5. Does my supervisor, or someone at work, seem to care about me as a person?
7. At work, do my opinions seem to count? (Buckingham & Coffman, p.33).

These action-oriented questions provide frontline leaders and organizations with valuable information about employee perceptions. High scores indicate clearly communicated expectations and a positive work environment in which the employee has the tools to do his/her job and feels valued. Conversely, low scores on these questions correlate with low job satisfaction and increase the potential for the employee to leave.

Anthony et al. (2005) indicate, "Nursing retention is both an expectation and a major responsibility of the NM [nurse manager] role that has both organizational and professional implications" (p. 146). Strachota et al. (2003) conducted telephone interviews with 84 nurses who left their nursing positions. The nurses interviewed indicated dissatisfaction with staffing levels (37%), management support (37%), and factors relating to hours worked (37%). Fifty-two percent of these nurses voiced concern with hospital or nursing unit leadership. It is interesting that although the nurses left their job, Strachota et al. found none of the 84 nurses interviewed left the profession of nursing. Their study found that nurses seek a supportive environment that recognizes their hard work.

While nursing leadership at all levels of the organization is key to any effective solution to the nursing shortage, the frontline supervisor has the most profound influence on a nurse's intent to stay (Buckingham & Coffman, 1999; Corning, 2002). A direct relationship exists between organizational commitment and nursing leadership behaviors (Herrin et al., 2007; McNeese-Smith, 1997). Behaviors contributing to organizational commitment include empowering staff, visionary leadership, encouraging professional development, recognizing staff accomplishments, shared governance in problem solving, and individual respect and consideration (McNeese-Smith). Training nursing leaders to actualize these behaviors can contribute to increased staff retention.

Leadership style plays a key factor in organizational commitment. Volk and Lucas (as cited in Force, 2005) were among the early researchers to suggest that a participatory management style was related to increased job satisfaction and decreased expected turnover. In contrast, nurses report lower levels of satisfaction with authoritarian managers leading to decreased organizational commitment.

Managers who use an authoritarian or transactional leadership style are less likely to allow employees to have voice and participate in decision-making. Question 7 from the Gallup survey assesses whether employees feel they are given an opportunity to participate in decision-making. Brewer et al. (2006) identified *lack of empowerment* as barrier to retention. In this study, nurses indicated a desire to have a greater voice in decision-making. These nurses expressed frustration in feeling powerless to change work conditions. Strachota et al. (2003) who report, "Nurses tended to stay on the job longer

when managers used a participative model and encouraged staff input into decision-making" (p. 112), corroborate this finding.

In addition to identifying job dissatisfaction as a key barrier to retention, organizations must also concentrate on issues facing their aging workforce. The physically demanding nature of nursing presents a challenge to older nurses. Larkin (2007) speaks to the paucity of research on how to retain the older nurse. She addresses many issues covered in the *Wisdom at Work* report published by the Robert Wood Johnson Foundation (RWJF) in 2006. This seminal document describes strategies specifically aimed at retaining older, experienced nurses. In this report, frequently cited reasons for nurses leaving a hospital include heavy patient workloads, staffing shortages, and physical and emotional demands of the job. Emotional factors contributing to job dissatisfaction pertain to feeling unappreciated and undervalued by physicians and hospital leaders. RWJF, in conjunction with the Lewin Group, have offered 13 grants to hospitals to develop evidence-based strategies for retaining the experienced nurse.

Current and future nursing workforce shortages make it incumbent upon organizations to stem the flow of nurses leaving. Nursing turnover compromises patient care and adds to the cost of healthcare (Strachota et al., 2003). The costs of experienced RNs leaving come through lost productivity, loss of expertise, and the negative effect on patient care. Sullivan et al. (2003) state, "A critical review of the literature also revealed substantial discussion of the pivotal nature of this management role in influencing nurse satisfaction, recruitment, and retention, and in ensuring quality of patient care and patient safety" (p. 544). Stable workforces reduce direct and indirect expenses associated with

turnover and positively impact quality and continuity of care (Anthony et al., 2005; Bondas, 2006; Force, 2005).

The literature reviewed show a strong correlation between nursing leadership, staff job satisfaction, and turnover/retention. In addition to training frontline nursing leaders to demonstrate transformational leadership and EI, what skills, knowledge, abilities, and attributes support and buttress effective nursing leaders? The next section addresses what the literature shows on these areas.

Skills, Knowledge, Abilities, and Attributes

This study targets frontline nursing leaders in an acute care hospital and the competencies they perceive as important for retaining staff. In searching for literature regarding this topic, a paucity of peer-reviewed, research articles were found relating specifically to frontline nursing leader competencies. To locate studies on this topic CINAHL served as the primary database because of its relevance to nursing. The key words *leadership* and *competencies* resulted in no results when the search was refined by selecting *peer-reviewed, research,* and *inpatient* for 1997-2007. When *inpatient* was removed, 40 articles met the criteria. After reviewing the abstracts, the selection narrowed to six articles. Of these six, the two from Canada were unavailable for electronic access. Differences in healthcare systems between the U.S. and Canada decreases the significance of these two studies to this study. Only two of the remaining four specifically targeted frontline nursing leaders. Limited available literature on the specific study topic prompted the researcher to expand the literature search and to broaden the scope of the search to include SKA and attributes identified in other studies,

articles, and documents pertaining to not only to frontline nursing leaders but to nurse executives as well.

The review of the literature revealed two models of nursing leadership competencies. In 2005, the American Organization of Nurse Executives (AONE) published their model for nurse executive competencies (Shirey, 2007). This model comprises of four major competency categories: communication and relationship management, knowledge of health care environment, professionalism, and business skills and principles. Central to and interlinking these four competencies is a fifth competency, leadership. Each competency is further delineated by a comprehensive skill and knowledge set. AONE states these competences are common to all nurse executives; however, the nurse executive's position within the organization determines the importance or emphasis on a skill or competency domain. Information available for this model does not delineate the process by which this model was created other than to acknowledge members of the AONE 2004 Education Committee. Because this competency model specifically targets the nurse executive position, it begs the question of what competencies also pertain to the frontline nursing leader. Does the competency model apply to frontline nursing leaders or are differing skills sets required for these two positions? If similar skill sets are required, which ones pertain to both levels of leadership? And, of interest to this study, which of the competencies facilitate staff retention?

In 2007, Sherman et al. published the *Nursing Leadership Competency Model.* This model delineates six competencies: personal mastery, financial management, human

resource management, interpersonal effectiveness, caring, and systems thinking. Sherman et al. explicitly describe the process by which this model came to fruition. Although not published until 2007, the authors conducted the study in 2002 in Florida. Following a qualitative design, 120 frontline nursing leaders participated in face-to-face interviews using purposeful sampling. Participants were stratified into two groups based on years of experience as a nursing leader—those with over 2 years of experience (n=98) and those with less than two years of experience (n=22). The experienced nursing leaders had an average of 10 years in their current position; whereas, the average tenure for inexperienced leaders was 16 months. Data collected was analyzed using grounded theory. From this data, the six competency categories emerged. Within the six competency categories, the authors cluster the skills, knowledge, attitudes, and behaviors described by the participants. This study represents the most comprehensive study reviewed for frontline nursing leadership competencies. It is, however, not without limitations. The study included participants from a single geographic area. Because nurse executives from 24 participating organizations chose which nursing leaders for the authors to interview, bias in selection cannot be ruled out. The authors disclose that the model has not been tested. Despite these limitations, this study provides valuable information on frontline nursing leader competencies. This study sought to determine if geographical differences exists and whether the findings of this researcher's study on behaviors promoting staff retention support the competency model described in the study by Sherman et al. The *Nursing Leadership Competency Model* contains many of the

elements found in the AONE nurse executive model. These similarities might be attributed to the fact that Rose Sherman helped to create both models.

Also available from the AONE is a *Nurse Manager Leadership Collaborative Learning Domain Framework* and *Nurse Manager Inventory Tool* (aone.org). This framework and tool are designed to assess the manager's current perceived level of functioning along three domains. These domains include Managing the business, Creating the leader in yourself, and Leading the people. The inventory tool provides a mechanism for the manager to conduct a self-assessment in which the manager rates his/her performance/knowledge on a scale from minimal skill to expert. The manager's supervisor also completes the inventory tool on the manager's skills, knowledge, and abilities. The scores are then compared and opportunities for improvement become part of the manager's developmental plan. The tool is quite extensive and in some respects ambiguous and unattainable. For example, under the Managing the Business section, subcategory "Foundation Thinking Skills," the manager is asked to score the statement, "Complex advanced systems definitions and applications." The vagueness of the statement renders it impossible for a manager to knowledgeably score this element. In addition to this statement, in the Creating the Leader in Yourself section, it suggests professional certification within one's specialty or field. While this requirement might be achievable for a frontline manager with frequent clinical practice, it is unattainable for managers not performing direct patient care. Although it is unclear exactly what level of manager the AONE *Nurse Manager Inventory Tool* is designed to evaluate, many of the

elements covered pertain to skills, knowledge, and abilities found in the literature for both the nurse executive and the frontline nursing leader.

Conger and Ready (2004) delineate both the reasons why organizations choose to use competency models and the limitations of competency models. Organizations employ competency models because they provide "clarity, consistency, and connectivity" (p. 43). These models outline the behaviors expected of the leader and form the foundation of the developmental plan. Three limitations of competency models are identified: "*complicated, conceptual,* and built on *current* realities" (p. 44). The comprehensive nature of the models increases their complexity and often creates an idealized view of the leader's role and responsibilities. Few leaders possess all of the competencies identified. In attempting to create a universal model, the model "fails to recognize that leadership requirements vary by level, culture, and situation" (Conger & Ready, 2007, p. 45). The last limitation pertains to future applicability. In a rapidly changing environment, the skill sets of today's leaders may vary from those of future leaders. By examining strategic and future-oriented plans, organizations can project what skills will be needed, and hire and train to those competencies. Rather than focusing on an expansive checklist of competencies, Conger and Ready recommend that organizations identify and focus on a few competencies that will help it reach its future goals. This study strove to identify those competencies that contribute to staff retention.

Value exists in determining SKA and attributes for frontline nursing leaders. This information provides the foundation for training current and future nursing leaders, developing job descriptions, evaluating nursing leader performance, and creating a

developmental plan to alleviate gaps in SKA (Contino, 2004; Sellgren et al., 2006). Table 3 (located on page 20) contains a listing of the SKA compiled from the many studies, documents, and articles reviewed. This list contains the most frequently mentioned SKA and is not meant to be all-inclusive. The SKA list was organized based on similar traits of the competencies. The list was then collapsed into two competency categories, Professional and Administrative. The Professional category is subdivided into two subcategories: Relationship with Staff and Personal Mastery.

The Relationship with Staff subcategory describes the ways in which the nursing leader interacts with the staff and includes the most frequently mentioned competency, communication. Communication was mentioned in all the literature for which competency identification was the objective. All but four articles in the literature reviewed mentioned the importance of effective communication. Also included in the Relationship with Staff category is EI/social awareness.

The second category under Professional is Personal Mastery. This domain includes the leader's personal and professional dimensions and development. Personal Mastery helps to clarify and develop the leader's purpose, values, vision, and talents. This subcategory contains competencies such as visioning, decision-making, professional development, and analytic/systems thinking.

The Administrative category is subdivided into four categories: Manager Role, Human Resource Management, Fiscal, and Outcomes. The Manager Role category contains competencies pertaining to the day-to-day operations of the clinical nursing unit.

The most frequently mentioned competencies found in the literature for Manager Role are staffing, regulatory bodies (e.g. TJC), and safety.

The Human Resource Management category contains the competencies related to recruiting, hiring, evaluating, and counseling staff. The most frequently mentioned competency in this category was retaining staff. This category also includes competencies for recognizing and praising staff and cultural competency. As the nursing workforce becomes more diverse, nursing leaders will need to demonstrate cultural awareness and understanding. “While minorities made up 11 percent of the overall RN workforce in 2004, they constituted 36 percent of NSP [Nursing Scholarship Program] awardees, 21 percent of NELRP [Nursing Education Loan Repayment Program] awardees and 26 and 22 percent of nursing school students and graduates, respectively” (GAO, 2007, p. 14). The increase in scholarship awards to minorities should translate into a more diverse nursing workforce in the near future. Cultural competency also includes consideration of gender and generation. Between 1980 and 2000, the number of male nurses in the workforce doubled from 2.7% to 5.4 % (Hemmila, 2002). Four generations make up the current workforce. Nursing leaders face a workforce espousing varying values, beliefs, and work ethics. The Human Resource Management category and the Relationship with Staff category are critical to maintaining a unit’s workforce and creating a positive work environment.

Another subcategory under Administrative is Fiscal. Although it is by far the smallest category, it contains competencies vital to the solvency of the unit and ultimately, the organization. Competencies included in this category include budget,

payroll, and balancing costs and quality. The elements in this category affect the ability of the leader to provide the staff with the tools, including human capital, to do their job right, thus ultimately influencing staff job satisfaction—a key element in retaining talent.

The final category under Administrative is Outcomes. This category provides a benchmark by which the leader can evaluate the effectiveness of the other categories. Included in this subcategory are patient focused measurement (e.g. patient satisfaction scores), quality management/process improvement, and risk management. Research/evidence-based practices are included in this category since they have a direct impact on quality and are the basis of many process improvement projects. Staff and MD satisfaction scores also provide valuable markers of success and opportunities for improvement.

In addition to the two major categories of SKA, the literature described attributes or characteristics of effective nursing leaders. No one attribute emerged as being more significant or more frequently mentioned. Table 4 (located on page 21) shows a listing of attributes mentioned in the literature. Studies from which the competency categories were derived are marked with an asterisk in the *Literature Cited* section. Additional references contributing to the list of competencies and attributes are marked with two asterisks.

This section covered a wide variety of SKA and attributes identified from the nursing literature for effective leadership. The limited number of primary studies done on frontline nursing leadership competencies necessitated the expansion of the search to include studies, reports, and articles related to nursing leadership, but not specific to frontline nursing leaders. Two major competency categories were identified: Professional

and Administrative. These categories were subdivided and specific competencies entered. Retaining staff ranked as the most frequently mentioned competency in the HRM category. Of interest to this study is what specific behaviors frontline leaders exhibit to achieve this competency. In addition to demonstrating leadership competencies, the literature described numerous attributes of effective leaders. While there are limitations to competency models, they provide a starting point for the development of job descriptions, evaluations, and developmental plans. This information is also helpful to university and hospital-based education and training programs. The next section of the literature review explores nursing leadership education and training.

Nursing Leadership Education and Training

> The truth is that leadership is *an observable set of skills and abilities* that are useful whether one is in the executive suite or on the frontline….And any skill can be strengthened, honed, and enhanced, given the motivation and desire, along with practice, feedback, role models, and coaching (Kouzes & Posner, 2007, p. 339-340).

Wong and Cummings (2007) warn of a developing shortage of nursing leaders. A 2006 survey conducted by Hodes Healthcare Division reported the average age of nursing leaders is just over 50 and 8% of these nursing leaders plan to retire in 2010. Projections indicate that by 2020 75% of the current nursing leadership will have retired. Managers in the study conducted by Sherman et al. (2007) identified retirement within the next 5 years as a short-term goal. Failure of the healthcare industry and academia to prepare for this impending exodus will result in a significant brain drain with the loss of corporate, clinical, and leadership knowledge. Preparing for the future requires examining the status of current education and training, identifying the SKA and attributes needed to move

organizations toward future goals, and determining how and when future nursing leaders will be trained. This section of the literature review examines the following aspects of Nursing Leadership Education and Training: historical/traditional nursing leadership preparation, educational requirements, usefulness of this study information, and professional development.

Historical/Traditional Leadership Preparation

The pathway to nursing leadership varies for each individual and organization. Healthcare organizations often promote individuals to leadership positions "without the experience, educational background, or on-the-job education in leadership that would help them to be immediately successful" (Kerfoot, 2007, p. 178). Bondas (2006) indicates a scarcity of research on nurses' motives and reasons for pursuing a career in nursing leadership. In Bondas' study, only 16 of the 68 participating nursing leaders intentionally made nursing leadership a career choice for what Bondas termed altruistic purposes. These nurses sought new knowledge and education to assist in their role. Eleven nurses sought leadership positions to gain power and for egotistical reasons. The remaining 41 nurses either had the choice made for them or accepted the position as a temporary assignment. For these last two groups, education on nursing leadership was often missing. Bondas' study illustrates that the path to nursing leadership is seldom a conscious choice and that education and training for nursing leaders remains problematic.

Gould et al. (2001) indicate that since the 1980s, studies have tended to overlook the need for professional development for clinical nurse leaders. Sherman et al. (2007)

found that most nurse managers in their study received minimal orientation, and it often occurred months after the manager assumed his/her position.

Recognizing the importance of nursing leadership training, in 2000 the UK government “announced plans to provide all ward sisters and charge nurses with an educational programme of clinical leadership” (Gould et al., 2001, p.8). Gould et al. identified components of clinical leadership the respondents felt important for their role. The perception nursing leaders in their study indicated that they had received poor or very poor preparation to perform a significant number of these leadership functions. They concluded that access to training in these areas would influence job satisfaction, confidence, and would ultimately influence recruitment and retention of qualified staff nurses. This finding mirrors that of Sherman et al. (2007) who report higher job satisfaction among experienced managers as compared to novice managers.

Since many nursing leaders do not intentionally choose the role, career planning does not occur. Trial and error serve as the predominant method for novice managers to learn the nursing leadership role (Sherman et al., 2007). Anthony et al. (2005) conducted a study with experienced nurses and managers currently working as frontline managers. These nurse managers (NM) “told of their trials and tribulations as they moved through stages of NM novice to NM expert” (Anthony, p. 153). A shift in paradigm must occur in order to view nursing leadership as a specialty practice (Herrin et al., 2007). The following section looks at this change in mental models by examining how nurses are educated and what level/type of education should be required for future nursing leaders.

Educational Requirements

The literature notes a lack of formal preparation for the transition and development of clinical nurses into management and leadership positions (Anthony et al., 2005; Bondas, 2006; Duffield & Franks, 2001; Gould et al. 2001; Sherman et al., 2007). In Bondas' study, 24% of the participants reported having no administrative education. She goes on to indicate, "There seems to be a lack of an education for future nurse leaders providing a thorough knowledge of nursing care as an evidence-based practice as well as leadership, organizational and economic issues" (p. 339). The work of Duffield and Franks (2001) support these findings and reinforce the importance of recruitment and education in nursing leadership.

Undergraduate nursing schools, which focus predominantly on clinical nursing skills and knowledge, provide a limited amount of nursing leadership education. The literature show an ongoing debate on what level of education should be required for nursing leaders now and in the future. According to Bondas (2006), "The matters concerning the educational requirements for healthcare leadership positions, and the rights to administrative authority, have not been settled since the days of Florence Nightingale" (p.332-333). The necessity of a Master of Science in Nursing (MSN) degree varies depending on who is asked and in what organizational position he/she occupies.

Almost half of the participants (n=43) in the study conducted by Scoble and Russell (2003) identified a MSN as the ideal preparation for a leadership position (n=18). Participants in this study worked in a wide variety of positions: executive level, education (dean and faculty), frontline nursing leader, and graduate student. Kleinman (2003)

conducted a study with 35 nursing managers and 93 nursing executives. While both groups felt a MSN enhances employability and job opportunities, they differed in whether a graduate degree is necessary for job performance. The demographic information for this study reveals that 69% of the nursing managers participating did not have a graduate degree compared to only 16% of the nurse executives without a graduate degree.

As the role of the frontline nursing leader continues to evolve and more administrative duties are pushed down to this level, forward thinking organizations will need to evaluate what level of education will provide future nursing leaders with the SKA to meet organizational goals. For some organizations, a MSN has become the minimum level of education for a frontline nursing leader position. Organizations, such as the Virginia Commonwealth University Healthcare System (VCU) and Methodist Le Bonheur Healthcare (MLH), have changed educational requirements for leadership positions. VCU requires frontline nursing leaders to have a master's degree. MLH set minimum requirements at the Baccalaureate in Nursing level and will increase the requirement to a master's level by 2010 (Herrin et al., 2007).

A barrier to acquisition of a MSN is the nursing leader's time and scheduling. The demands of a 24/7 position make continuing education and graduate school a challenge. Menix supports the assumption of specifically trained nursing leaders in stating, "without appropriate education preparation nurse managers may not have the competencies to effectively manage accelerated change" (2000, as cited in Contino, 2004, p. 57).

Organizations moving to requiring a MSN must creativity look for ways to support nursing leaders in achieving this goal.

Viewing nursing leadership as a separate specialty within nursing necessitates gearing education and training toward the SKA needed to perform successfully in this role. Academic curriculums must meet the needs of the organizations served by their students. Before education can be conducted, program planners must determine curriculum content. Sullivan et al. (2003) speak to the limited number of studies conducted with leadership development and experiences of nursing managers as the primary study objective. Whereas many of the previous studies focused on SKA for nursing executives, this study sought to learn what competencies frontline nursing leaders report that they need to know in order to succeed with a specific focus on the behaviors pertaining to the competency staff retention. Although many competencies apply to both levels of nursing leadership, Conger and Ready (2007) contend, “Leadership skills at the executive level are often significantly different from those at the middle ranks” (p. 45). This study focused specifically on the frontline nursing leader position. The next section outlines ways in which the data gathered for this study might be useful to academia and healthcare organizations.

Nursing Leadership Preparation

The usefulness of the data collected in this study is predicated on three major domains: competency identification; human resource management and development; and education. Competencies form the foundation for the education and practice of frontline nursing leaders (Barker et al., 2006). Competencies describe a specific set of behaviors,

actions, and accountabilities those in a specific role must successfully perform. Competencies provide a mechanism for conveying expectations of a role, for evaluating whether the individual meets these expectations, and for devising a developmental plan for areas requiring improvement (Contino, 2004). These role-specific, evidenced-based expectations should be clearly delineated in competency-based job descriptions, which in turn merge into performance evaluations. Snow (2001) asserts, “Nursing lags behind other industries in teaching and supporting research-based leadership theory that is linked to performance” (p. 440). In reviewing most admired organizations, Snow reports that these organizations use competency models and developmental programs in selecting and promoting their leaders. Contino (2004) and Sellgren et al. (2006) support the supposition of using competencies as a means for selecting leaders.

In addition to the organizational and individual benefits, explicitly defined competencies provide a conceptual framework for collegiate and hospital-based education and training programs. Administrations often hire many nursing leaders because of their clinical competence. The literature reveals that many frontline nursing leaders do not possess graduate degrees in Nursing Administration/Leadership and that they feel inadequately prepared for the role. A delay in formal training leaves a new nursing leader floundering and operating in a trial and error mode. Kleinman (2003) suggests that nursing leaders are less prepared for the leadership and management role than for the clinical role. Current changes in the healthcare industry necessitate a broad knowledge base that requires nursing leaders to have business management knowledge and skills in addition to clinical competence. MSN in Administration/Leadership

programs need to focus on the SKA that nurse leaders need to know to perform this expanded role. Scoble and Russell (2003) recommend coordinators of graduate programs ascertain employer needs and perceptions about the “knowledge and skill deficits in new managers” when designing curriculum. While some SKA may be similar for business and healthcare organizations, graduate programs need to consider the context within which the leader will function—its constraints and opportunities (Avolio & Bass, 1998).

The study by Scoble and Russell (2003) with 43 nursing leaders of varying levels of responsibility yielded 173 items for curriculum content. These items were then categorized into 18 content groups. The business administration group contained the highest number of items with 23. The second largest content group pertained to leadership with 22 items related to this topic. This study illustrates the desire of nursing leaders to learn more of the business and leadership competencies.

Leadership competencies comprise the SKA for human resource management and communication. Based on the previous discussion on leadership styles, nursing leaders need training on transformational leadership (Avolio & Bass, 1998; Barling et al., 2000) and emotional intelligence. Corning (2002) indicates a deficiency in training programs for nursing leaders related to the top “soft-skill” competencies, which are people-oriented. The study recommends hospitals design professional development programs that build on the people skills.

Emotional intelligence (EI) serves as an adjunct to transformational leadership when training for relational skills. Emotionally intelligent individuals demonstrate Self-Awareness, Self-Management, Social Awareness, and Relationship Management

(Emmerling & Goleman, 2003). Mastery of these domains leads to success in the workplace. Emotional competencies “represent the degree to which an individual has mastered specific, skills and abilities that build on EI and allow them greater effectiveness in the workplace” (Emmerling & Goleman, p. 16). Competency implies a learned skill, which can be taught as part of leadership training. Emmerling and Goleman emphasize that emotional intelligence is a more powerful predictor of becoming an outstanding leader than IQ. Snow (2001) found that leaders in the most admired companies participating in the study demonstrated high levels of emotional intelligence. Given the relationship between nursing leaders, job satisfaction, and retention, training leaders in emotional intelligence seems prudent.

This section explored the literature on nursing education and training. It began with a discussion of pathways into leadership, identifying that most nurses did not plan a career in leadership but happened into it. The next section highlighted the lack of formal preparation of nursing leaders prior to moving into the position. Fewer frontline nursing leaders than nurse executives perceived the need for graduate education to successfully perform the role. The literature review supports several useful benefits of this study. These include the identification of role specific competencies that can be used to create job descriptions and performance evaluations. The competencies identified in this study can also guide curriculum development for graduate programs in Nursing Administration/Leadership and for healthcare organizations in devising professional development programs. For those nursing leaders not pursuing a graduate degree,

professional development is highly recommended to acclimate them to their role and train them in the competencies that promote retention of staff.

Conclusion

The literature review took a broad look at nursing leadership from multiple perspectives. After a description of the methodology used to conduct the literature review, a discussion regarding the importance of this study and supporting literature followed. This section of the literature review first explored the question *What is leadership?* A manager was differentiated from a leader, emphasizing the centrality of relationships for leaders. The next section reviewed the literature on the influence of nursing leaders on employee job satisfaction. The literature revealed a strong correlation between nursing leadership, job satisfaction, and retention/turnover. The cost of nursing turnover highlights the importance in retaining experienced nurses. Loss of these nurses leads to brain drain and jeopardizes quality and patient safety.

The literature review then synthesized the data on skills, knowledge, abilities, and attributes of nursing leaders. Because of the paucity of data specifically on frontline nursing leaders, the search expanded to include data on nursing executives. This data was collapsed into two major categories of competencies: Professional and Administrative. The Professional category contained the subcategories of Relationship with staff and Personal Mastery. The Administrative category encompasses competencies related to the Manager Role, Human Resource Management, Fiscal, and Outcomes. Retaining staff surfaced as the most frequently mentioned HRM competency in the literature review. The

data from the literature review also provided a list of attributes; however, no one attribute appeared with more frequency than the others did.

The final section of the chapter delved into education and training for nursing leaders and the usefulness this study data provides. The literature suggests hiring based on clinical, cognitive, and emotional skills. Academic and healthcare organizations can utilize research to design programs to foster effective leadership development. Healthcare organizations can use the data to develop competency-based job descriptions and evaluations as well as professional development programs.

This chapter focused on the importance of frontline nursing leaders and their role in alleviating the nursing shortage through competency development with an emphasis on the staff retention competency. The literature reviewed supports the need, the purpose of this study, and how the results of this study can be used. Chapter 3, the methodology, delineates the study design.

Chapter 3 Methodology

Introduction

Chapter 2 identified a broad spectrum of key literature pertaining to nursing leadership and competencies as they relate to staff retention. This chapter describes the process by which the researcher conducted this study on frontline nursing leaders' perceptions of behaviors and attitudes influencing staff retention. The first section offers a discussion of the research design and rationale. The next section delineates the research questions this study sought to answer. A discussion of grounded theory supports the methodology selected for this study.

The section on site and participant selection describes entry into the research site and criteria for participant inclusion in the study. The procedure and data collection section outlines the process by which the researcher conducted the study and the methodology for data collection. Data analysis using grounded theory is then described. Inherent in research are ethical considerations and participant protection. Safe-checks employed are discussed, including informed consent and Institutional Review Board (IRB) approval. The chapter concludes with a discussion of study delimitations.

Research Design

Introduction and Rationale for Design

The research design describes the plan for collecting and analyzing data in order to answer the research questions (Flick, 2007a). The appropriate selection of methodology forms an integral part of the research design. The researcher determines which data collection method, quantitative or qualitative, will best provide answers to the research questions (Corbin & Strauss, 2007). Researchers collect quantitative data when they desire to establish relationships between measurable variables. Quantitative studies can test existing theories and provide statistical descriptions. While quantitative studies seek causal explanations, qualitative studies seek to understand the perspectives of the participants' lived experiences and how they construct the world around them (Flick, 2007a). The researcher interprets phenomena in terms of the meanings people assign to them. Qualitative studies help in understanding social situations from the participants' perspective and within the context with which the phenomena occurs. This methodology aids in developing sensitive concepts, describing multiple realities, creating grounded theory, and providing narrative descriptions that enhance understanding (Marshall & Rossman, 2006; McMillan & Schumacher, 2006; Neergaard & Ulhoi, 2007). Denzin and Lincoln (2005), noted authorities on qualitative research, describe qualitative research as an interpretative and naturalistic approach in which the researcher studies a phenomenon in its natural setting and interprets the data collected based on the meanings the participants give to it. The goal of qualitative research is not to test hypotheses as is done

in quantitative research (Flick, 2007a). Instead, qualitative research allows concepts to develop and refines them throughout the process to more accurately reflect reality.

The nature of the findings in a qualitative study makes them contextually bound and are not expressly intended for generalization (Flick, 2007a), although the reader of the study can generalize/compare findings to his/her reality. Qualitative research bases its assumptions on a socially constructed reality in which variables are "complex, interwoven, and difficult to measure" (Glesine, 2006, p. 5). In qualitative research designs using grounded theory, the goal is to create a substantive theory, which applies to a specific field. The reader derives potential generalizations from this theory.

The limited research on frontline nursing leaders' competencies inhibits the ability to conduct meaningful quantitative research. The goals of this study are identification of specific behaviors and attitudes for competencies contributing to staff retention and determination of the education and training needed by this group of leaders to gain proficiency in these specific competencies. A qualitative design is well suited to accomplishing these goals. McMillan and Schumacher (2006) identify two major purposes of qualitative research, "*to describe and explore* and *to describe and explain"* (p. 316). The exploratory nature of qualitative research makes this methodology ideal for learning more about a previously little known topic. The sparse literature on competencies for frontline nursing leaders provides support for further studies in this area. The current and projected nursing shortage makes learning which competencies and behaviors influence staff retention a priority. Qualitative research using grounded theory provides a foundation upon which future qualitative or quantitative studies can build.

Qualitative and quantitative studies complement one another to develop rich contextual descriptions of frontline nursing leadership. Grounded theory takes the research a step further in that the ultimate goal involves theory generation.

Grounded Theory

Defining Grounded Theory

Grounded theory methodology has its roots in symbolic interaction (Robrecht, 1995), which holds the assumption that individuals "act and interact on the basis of the meaning of objects and their interpretations" (Flick, 2007a, p. 120). Neergaard & Ulhoi (2007) define grounded theory as a "*theory derived from data that has been systematically collected and analyzed using an iterative process of considering and comparing earlier literature, its data and the emerging theory*" (p. 123). Glaser and Strauss (1967), pioneers of grounded theory, describe it as a process of using constant comparative analysis to compare data within and between the participants, looking for common and differing characteristics and themes. Coding and categorizing the data allows themes to emerge. These themes lead to the generation of a substantive theory. The actual process of conducting a grounded theory study varies depending on which paradigm the researcher chooses to follow.

Various Paradigms of Grounded Theory

There exist three primary perspectives on conducting grounded theory research (Charmaz, 2000; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Each author offers criticisms of the others' methodology and takes a differing ontological and epistemological stance.

Prior to differing in perspective, Glaser and Strauss (1967) assumed a positivistic paradigm (Kelle, 2005). In the positivism perspective, “only knowledge of phenomena confirmed by the senses can be warranted as knowledge” (Flick, 2007a, p. 11) and the researcher collects data in a “value-free” manner (p. 12). The positivistic paradigm holds that reality can be ascertained through research in which the researcher is objective and does not influence the phenomenon being studied (Annells, 1996). Opponents of this approach criticize it as “naïve realism” (Annells, p. 384).

Strauss and Corbin in the mid-1990’s espoused a post-positivistic approach; however, since then they have shifted slightly toward a constructivist approach (Neergaard & Ulhoi, 2007). Guba and Lincoln (1994) also use a post-positivistic paradigm. The post-positivistic paradigm, known as “critical realism,” holds that although reality exists, it cannot be fully comprehended (Annells, 1996).

Charmaz (2000) promotes a constructivist approach, the third primary paradigm of grounded theory. Glaser (2002) cites Charmaz (2000) in saying, “Constructivism assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understanding of subjects' meanings” (para. 7). A relativistic ontology holds that reality consists of constructed realities bound by time and place (Annells, 1996). Glaser (2002) offers scathing criticisms of the constructivist stance in his document, *Constructivist Grounded Theory?* He argues for the incongruence of constructivism and grounded theory, calling it a “misnomer” (para. 1). In so stating, he goes on to say that the over concern for data accuracy seen with Qualitative Data Analysis (QDA) should not be applicable to

grounded theory since grounded theory includes all data—observations, interviewee words and perceptions, and environmental clues—without the onus of verifying mutual interpretation of the data by the researcher and the participant.

Glaser (2002) endorses interview questions that do not lead interviewees to give desired responses or in the researcher's desired direction. He also proposes delaying the literature review until after the data collection in order to prevent exposure to competing theories related to the phenomena of interest (Kelle, 2005). Exposure to competing theories may prevent the researcher from objectively analyzing the data collected (Gall, Gall, & Borg, 2007). This stance supports Glaser's assumption that theory emerges from the data, rather than from prior or *a priori* knowledge. This perspective places emphasis on the value of emic viewpoints to generate theories.

Not all researchers employing this methodology ascribe to Glaser's view of grounded theory. Flick (2007a) calls it a myth that qualitative research does not derive from existing theories. Flick offers four forms of theoretical knowledge to support this supposition. First, previous theories inform current research. Second, how the research is framed is based on a theoretical perspective and the underlying assumptions for the perspective. Third, existing literature and research form the basis of theoretical knowledge. Lastly, theoretical assumptions influence data collection strategies. Each of these forms influences how the researcher plans and conducts research. Kelle (2005) concurs in stating, "It is impossible to free empirical observation from all theoretical influence" (para. 5) since prior knowledge about the situation, action, or experience shapes the interpretation of the observation. This theoretical knowledge "provides the

categorical framework necessary for the interpretation, description, and explanation of the empirical world" (Kelle, para. 51). Bruce (2007) further supports this stance in saying, "Induction and prior theory examination must be seen not as oppositional but as complementary." The researcher views data through some preconceived interpretative lens. In this study, the literature review and theories on nursing leadership shape the interview guide and color the lenses through which the researcher collected and analyzed the data. Harry et al. (2005) suggest the use of reflexivity to prevent this situation from being an obstacle in qualitative research. Reflexivity, discussed later in this chapter, serves as a means to enhance validity and credibility of the findings.

Another point of divergence for Glaser and Strauss pertains to epistemology. Glaser maintains that the researcher is independent of the method. This viewpoint supports an objectivist epistemological view. Strauss and Corbin (1998; 2007), on the other hand, lean toward a subjectivist and transactional epistemology (Annells, 2007) leading toward a more constructionist paradigm. As such, Strauss and Corbin view the researcher as actively involved in the methodology and interprets data from multiple perspectives. The researcher draws on experiential knowledge when collecting and analyzing data. Bruce (2007) describes it as a "give-and-take relationship between the researcher and the situation being investigated" (p. 10). In addition to the above-mentioned criticisms, Glaser also criticizes the systematic manner in which Strauss and Corbin collect and analyze data as being too prescriptive and structured (Creswell et al., 2007). Glaser criticizes Strauss and Corbin for "forcing" the data into categories versus allowing the categories to emerge from the data (Kelle, 2005).

Despite the criticisms of each perspective, none of the differing paradigms for grounded theory has proven superior to the others (Neergaard & Uhloi, 2007). With consideration given to criticisms of each perspective, this study follows the ideations most closely aligned with Strauss and Corbin's more recent methodology for grounded theory (1998; 2007). More specific details and descriptions of data collection and ground theory methodology for this study occur later in this chapter.

Rationale for using Grounded Theory

Situated in the sociology discipline, a grounded theory design is best suited to address problems or questions in which no theory currently exists or in which current theories prove inadequate (Creswell et al., 2007). Grounded theory methodology strives to generate a general explanation (a substantive theory) of a process, action, or interaction shaped by the perceptions of persons knowledgeable about the phenomena (Creswell et al.). Theories generated from data more accurately reflect reality and possess a higher level of relevance than theories generated from prior literature, personal experience, or untested common sense (Neergaard & Ulhoi, 2007).

Research Questions

Alleviating the current and projected nursing shortage involves targeting recruitment and retention. The literature suggests focusing on retention as an advantage point. Retention poses a multifaceted problem in which nursing leadership surfaces as a key issue. Nursing leaders, by their behaviors and attitudes, can influence staff nursing turnover and intent to stay. Therefore, this study explored the perceptions of frontline nursing leaders of behaviors and attitudes that contribute to retention of staff nurses in an

acute care hospital. In addition to this central focus, this study explored to what extent nursing leaders felt current leadership education and training programs support their practices that promote staff retention.

Site and Participant Selection

The researcher selected participants knowledgeable about the role and behaviors of frontline nursing leaders using purposeful sampling. This strategy chooses groups or individuals likely to be knowledgeable, experienced, and informative about the phenomenon of interest (Flick, 2007a; McMillan & Schumacher, 2006). This study specifically and intentionally targeted frontline nursing leaders and does not espouse generalizability to other levels of nursing leadership. More specifically, the researcher employed comprehensive sampling in that all frontline nursing leaders in the study site meeting the criteria were invited to participate in the study, thus allowing the study to achieve redundancy, or saturation, of the data.

Data sources for this study included the perceptions of frontline nursing leaders in a large suburban acute care hospital in central Virginia. The researcher, who works at the facility as a Critical Care Clinical Nurse Educator, chose this site due to ease of accessibility and the potential value of the findings. Glesine (2006) enumerates the many advantages of choosing to conduct research in one's own institution. These advantages include "easy access; the groundwork for rapport is already established; the research would be useful for his/her professional or personal life; and the amount of time needed for various research steps would be reduced" (p.31). The researcher for this study received the full support of the Chief Nursing Officer (CNO) to conduct a research

project benefiting both the facility and the researcher. Appendix A includes a copy of the letter sent by the CNO to potential participants on behalf of the researcher. The *Ethics* section, presented later in this chapter, discusses concerns and issues related to conducting research in a site where the participants know the researcher.

The research site encompasses a large two-campus acute healthcare corporation that employs approximately twenty-two frontline nursing leaders of inpatient departments with direct oversight to approximately 1100 employees (RNs, LPNs, Nursing Assistants, and other unit support personnel). Collecting data within such a large organization provided a sufficient sample size to identify nursing leader perceptions of behaviors and attitudes influencing staff retention. The large network also allowed for variation in type and size of unit these leaders oversee upon which to collect data. The researcher maximized variation by inviting all frontline nursing leaders meeting inclusion criteria within the organization to participate in the study.

The eligibility requirement for participation in the study was a minimum of six months of employment at the research site in a frontline nursing leadership position. Participants in this study held the title of “Nursing Director” or “Interim Director” over the previous six months. All participants possessed direct oversight of the unit during this time. At the time of the interviews, all participants held the title of “Nursing Director.” To recruit participants in the study, the researcher presented the study purpose and goals to the nursing leadership team at their monthly meeting in October 2008. Written information regarding the study was provided at this time as well as the opportunity to ask questions of the researcher (See Appendix B). The researcher followed-up by

contacting each leader via e-mail to request participation and to schedule a time for an interview. This correspondence included the information provided in the nursing leadership meeting. The researcher reiterated voluntary participation in the study.

Approximately two weeks prior to the projected end of interview data collection, four nursing leaders had not yet scheduled an interview. The researcher sent a second e-mail request to the remaining four potential participants simply stating dates and time available for interviews. Two of these nursing leaders scheduled interviews. The remaining two did not respond after this second e-mail request. The researcher did not pursue it further so as not to create a perception of coercion. Of the potential 22 nursing leaders, 20 agreed to participate in the study. One nursing leader became ill, canceled the interview, and was unable to reschedule it prior to the end of the data collection phase, leaving 19 final study participants.

Study participants represented a variety of educational backgrounds, experience, and inpatient nursing areas. Nursing leaders from four Medical-Surgical areas and one specialty area did not participate in the study. Two of the Medical-Surgical units did not have a nursing director at the time of the study. The interim nursing directors of these units had not been in the position for a minimum of six months and therefore did not meet inclusion criteria. For the remaining two Medical-Surgical areas, one nursing leader canceled for illness reasons and the other chose not to participate. The units represented in the study also varied in size as measured by full time equivalencies (FTEs). Some nursing leaders provided oversight to multiple units, while others maintained responsibility for a single unit. Table 5 provides study participant demographics.

Table 5. Nursing Leader Demographic Information, n=19

	Mean (SD)	Minimum	Maximum
Years in Leadership	12.7 (9.1)	1.5	30.0
Years in Leadership at study site	8.0 (7.4)	.5	30.0
# of units managed	2.2 (1.6)	1	7
Total # FTEs[a]	47.9 (30.9)	8.5	116
Type of Unit	n		
Medical-Surgical or Telemetry	5		
Critical Care	6		
Women's Health	3		
Other: ED, OR, Pediatrics/PICU	5		
Highest Level of Education			
Masters	6		
Bachelors	7		
Associate Degree	5		
Diploma	1		

[a] Full Time Equivalencies (FTEs) based on actual employees on payroll. Open positions were not included in the numbers provided by Human Resources.

Procedure and Data Collection

Interviews and Instrumentation

Following a phenomenological perspective, the researcher sought to understand the frontline nursing leaders' viewpoint and meanings of lived experiences. Phenomenology studies the world from the individuals' perspective with the goal of understanding how individuals construct reality (Gall, Gall, & Borg, 2007; Marshall & Rossman, 2006). Interviews serve as the predominant strategy for this theoretical

perspective (Flick, 2007a). In order to learn the nursing leaders' perceptions, a single researcher conducted face-to-face, semistructured interviews. This strategy allowed the interviewer to obtain data on participant meaning—how frontline nursing leaders perceive their world and how they explain or make sense of these experiences.

The researcher conducted nineteen digitally recorded interviews with frontline nursing leaders over a five-week period between October 17 and November 24, 2008. The purpose of the interviews was to gain the perspectives of frontline nursing leaders on behaviors and attitudes influencing staff retention. A second goal of the interview was to ascertain what they perceive as the desired education and training necessary to attain these competencies. The interviews were semistructured in that the researcher used an interview guide with open-ended questions and followed-up with a variety of probes depending on the participant's responses (See Appendix C). The interview guide provided the interviewer with a list of questions and topics for exploration. Questions in the interview guide originated from the literature review and the topics delineated in the research questions. Care was taken to avoid leading questions in order to address the concerns mentioned by Glaser (2002) in his criticisms regarding constructivism.

The researcher conducted a pilot interview using the interview guide with two nursing leaders from outside the study's geographical area. The objective of the pilot interview was to provide the researcher with feedback on the interview guide questions and whether the questions elicited the relevant data. The digital recorder used for the pilot interview picked up a significant amount of background noise making the recording difficult to understand. This experience prompted the researcher to change the recorder

settings and to ensure the device sat close to the participant in subsequent interviews. Although the pilot interview provided adequate data on the topic of interest, the researcher excluded this data from data analysis. The pilot interview demonstrated adequacy of the interview guide for obtaining desired data.

The research site's CNO received a copy of the interview guide and was given the opportunity to make modifications prior to the commencement of data collection. The CNO requested no changes to the interview guide. Prior to the interview, the researcher electronically sent each participant the background information describing the study, thus allowing time for the participant to reflect on the topics and his/her experiences as a nursing leader. The participants also received a copy of the consent and a demographic sheet (See Appendices D and E). The researcher requested that the participant read the material and complete the demographic sheet prior to the interview. Specific instructions directed participants to read, but not sign, the consent form prior to the interview.

Interviews were conducted at the medical center in a variety of locations per the nursing leaders' request. Interviews occurred in the nursing leaders' offices, conference rooms, and the education office. By conducting the interviews in the facility where the nursing leaders work, it kept them in their "natural" environment and provided a frame of reference for focusing on their role as a nursing leader (Bogdan & Biklen, 2007; Marshall & Rossman, 2006). Despite conducting some interviews in the nursing leaders' offices, interruptions occurred infrequently with only one exception. The interviewer reviewed the demographic questions first to establish a rapport and help to focus attention. Most of the nursing leaders completed the demographic sheet prior to the interview as requested.

Demographic information was documented using a written survey and was not audio recorded to enhance participant confidentiality. The demographic sheet did not contain participant identifiers. Using the interview guide, the researcher asked all participants the same questions in virtually the same manner. This approach limited bias and assisted in comparative data analysis (Flick, 2007a). Probing and follow-up questions varied based on the interviewee's responses. Because of the emergent or reflexive research design, this guide underwent slight modification and revision as data was collected and analyzed. The researcher added one question and one probe to the initial interview guide. Question 10, "What do you think is the biggest challenge nursing leaders face related to staff retention?" was added initially as a probe during the first interview in response to the nursing leader's comment about the challenges of the position. The probe for this question became, "What keeps you coming back every day in the face of these challenges?" When brought up by the participant, the researcher asked probing questions regarding their perceptions of administrative or senior leadership support. Not all probes listed on the interview guide were utilized. Appendices D & E contain the interview guide and demographic questionnaire.

The influence on the participant of the researcher's presence in the field cannot be ignored. Flick (2007a) contends "that qualitative researchers do not act as an invisible neutral in the field, but that they take part when they observe (in participant observation) or make participants reflect their life and life history (in a biographical interview)," which as the participants reflected on the interview questions, they started to form mental models of their nursing leadership role and their place within the organization. These

ponderings ultimately were reflected in the responses they gave during the interview. The outside agent following up with the participants reported one incidence of this phenomenon. Nursing Leader #12 remarked, “It was a good experience for me personally, to encourage me to take a closer look at myself and management.” Additionally, after undergoing reflective inquiry, the participant might decide to change a practice or to seek additional training for competencies he/she perceive as needing improvement.

Since the researcher has a formal position within the organization, exposure to frontline nursing leaders during the course of the study existed outside of the formal interviews. The physical presence of the researcher within the organization offered the potential to bring these reflections to the surface periodically, thus serving to remind the participant of any actions he/she may have committed to carry out.

The researcher digitally recorded and transcribed all interviews with participant permission. Audio recording ensured verbatim accounts of the interview. A professional transcriptionist typed the transcriptions for the researcher. Upon receipt of the transcript, the researcher listened to the recording and verified accurate transcription prior to forwarding the transcript to the participant. All but two participants received the transcript electronically. The remaining two, per their request, received printed copies of the transcript in a sealed envelope marked “Confidential.”

Participants were given the opportunity to review the transcripts and make modifications for clarity and accuracy. Prior to sending the transcript, the researcher activated the tracking function to expedite finding revisions. Only three participants

modified the transcript. One nursing leader added the unit turnover rate. Another removed extraneous speech such as, “like...you know.” A third rephrased several statements to clarify meaning. All participants approved their transcript, either as submitted or with minor revisions as mentioned above.

Notes taken during the interview assisted in reformulating questions and probes and for recording nonverbal communications. During the interviews, all participants appeared at ease with the interviewer and the interview process. Nursing Leader #15 commented to the outside agent, “The interview was low key and easy to answer. I felt put very much at ease considering I was being recorded.” Nonverbal communications, posture, speech tone, and gestures of the nursing leaders indicated comfort in discussing the topics. Only interviews with leaders 17 and 18 felt rushed. The interview with Nursing Leader #17 occurred late in the afternoon during a time in which a “crisis” occurred in the nursing leader’s unit. Nursing Leader #18 came 20 minutes late for the interview and needed to finish on time in order to attend a meeting scheduled immediately after the interview. Despite the perceptions of rushed, both nursing leaders provided valuable information that contributed to the body of data. The interview length ranged from 19:02 for the first interview to 43:46. None of the official interviews lasted the projected 60 minutes. The interviews averaged 33:15 in length. Of note is the frequency with which the nursing leaders continued to talk about the subject after the digital recording stopped. In one case, the discussion after the interview lasted longer than the 43-minute interview. The researcher captured this data in the field notes created after the interviews. The continued discussions seemed to relate more to the nursing

leaders' interest in the topic versus the desire to talk "off the record." It also provides evidence to the nursing leaders' level of comfort with the topic and the researcher.

Focus Groups

In addition to collecting data through interviews, the researcher conducted a focus group with four nursing leaders volunteering to participate in additional data collection and validation. Krueger and Casey (2000) support the use of focus groups to "determine the perceptions, feelings, and thinking of people about issues, products, services, or opportunities" (p.12). Focus groups allow participants to listen to the opinions of others and contribute their understandings of the phenomena of interest (Marshall & Rossman, 2006). During the focus group, the researcher encouraged participants to express their views in a supportive environment. The social nature of focus groups creates a more relaxed environment for data collection than one-on-one interviews (Marshall & Rossman). Initially, nine nursing leaders accepted the invitation to participate in an in-person focus group and two offered to participate in an on-line focus group. The researcher desired to have five to ten people for each type of focus group. Limiting the size of the focus group allows ample opportunity for each member to voice his/her opinions, views, and beliefs (Krueger & Casey, 2000). Due to the low interest in the on-line focus group, the researcher did not pursue this avenue. After scheduling the in-person focus group, one nursing leader declined to participate secondary to a conflict in her schedule. The remaining eight all accepted the electronic invitation. One volunteer canceled the week prior to the meeting. One canceled about an hour before the meeting by paging the researcher and two sent emails canceling. The researcher did not receive

the emails until after the focus group concluded. Unfortunately, all the nursing leaders from one of the campuses canceled, leaving the focus group with nursing leader from just one campus.

The researcher arranged the tables such that the participants sat around the parameter and faced each other. Handouts were placed around the table prior to the start of the focus group. A tin of candy sat in the middle of the table and the researcher offered it to the participants at the beginning of the session as well as giving permission to partake of the candy during the session. According to Krueger and Casey (2000), “Eating together tends to promote conversation and communication within the group” (p. 104).

At the scheduled time of the focus group, only two people were present. The researcher requested to wait a few minutes before commencing. A third nursing leader arrived about 5 minutes later. During the wait, the nursing leaders conversed quietly. The researcher encouraged them to review the handouts located on the table. One of the nursing leaders indicated that she spoke with another volunteer fifteen minutes prior and that this nursing leader intended to participate. She arrived a few minutes later. The nursing leaders exchanged cordial greetings with each other as they entered the room and took a seat, even teasing the final participant about being late when she arrived twelve minutes after the scheduled start time. The focus group participants represented a variety of unit types: Medical-Surgical, Women’s Health, Critical Care, and Telemetry. The four participants had a range of experience, from 1 year to 20 plus years. After a few minutes of chatting between the participants to allow a rapport to develop, the researcher officially started the focus group.

Since all the nursing leaders knew each other well, introductions were deferred. The researcher began the focus group by thanking the participants for taking the time to come to this meeting. In this study, the researcher functioned in an *interviewer* and an *inside observer* role context (McMillan & Schumacher, 2006). The researcher delineated these roles at the outset of the focus group. The researcher used an opening script to describe the purpose of the focus group, how the data will be used, procedures/format for the focus group, and principles of confidentiality. Appendix F includes a copy of the opening statements for the focus group. After reading the introduction, the researcher placed the digital recorder in the center of the table and started audio recording the session. Consent for participation in the focus group occurred during the one-on-one interviews.

The purpose of the focus group in this study centered on validation and triangulation of the data. The researcher presented the focus group with preliminary findings derived from the interview and artifact data. Focus group participants then discussed their perceptions of these findings. The participants listened to and responded to the views voiced by their peers. The researcher's objective revolved around having the participants support or refute the researcher's interpretation of the data.

In addition to audio recording for verbatim records, the researcher documented detailed field notes to record observations of participant interactions and nonverbal communications occurring during the focus groups. The use of the focus group increased the quality and richness of the data (McMillan & Schumacher, 2006). At the conclusion

of the one-hour session, the researcher offered the focus group participants the opportunity to member check the focus group transcript. All participants declined.

Documents and Artifacts

Qualitative research using grounded theory assumes a multi-method approach to data collection (Marshall & Rossman, 2006). In addition to interviews and focus group strategies, the researcher extracted data from documents and artifacts. In order to better understand the nursing leaders' perspective on staff retention and turnover, the researcher obtained data from Human Resources (HR) on these topics. The HR administrator provided information on Registered Nurse (RN) turnover for each unit. HR calculated the turnover rate based on all RN staff leaving the unit and does not differentiate voluntary turnover from hospital initiated termination or staff leaving the unit by transfer or promotion.

Additional helpful information obtained from HR included the job description for the frontline nursing leader position. This document describes what the hospital views as the primary roles and responsibilities for this position. The researcher reviewed the job description for information on experience and education requirements as well as skills, knowledge, and attributes (SKA) identified by the organization for this position. In addition to the job description, the researcher obtained the annual performance management plan or evaluation, which functions as a companion document to the job description. The researcher compared the performance management plan to the job description to determine congruence. Data collected from the job description and

performance appraisal was reviewed for consistency with and compared to the data collected from the nursing leaders regarding competencies and attitudes.

The researcher also worked with the site's Organizational Development Department to ascertain what educational programs they currently offer to nursing leaders. Data obtained included which of the current nursing leaders attended these programs within the last two years. Having attended leadership classes within the last two years may alter the perceptions of competencies that leaders deem essential or most relevant to retaining staff. The data collected from the nursing leaders and Organizational Development on training and education was used to answer the research question, "To what extent do nursing leaders feel current leadership education and training programs support their practices that promote staff retention?"

The use of multimethod data collection strategies facilitated the analysis of the data, validity checks, and triangulation. Triangulation enhances the quality of the study (Flick, 2007b). These concepts are discussed in the next section on data analysis.

Data Analysis

Inductive Process Using Grounded Theory

The researcher used several techniques to help organize, categorize, and identify emerging themes in the data. Glesine (2006) cites Wilcott (1994) in describing three means of data transformation: description, analysis, and interpretation. Description involves the use of recorded data, transcripts, and field notes. Verbatim transcription of the audiotaped interviews assured the accuracy of the data. The use of an interview guide standardized the interviews so that "differences in the data can more likely be drawn back

to differences in the interviewees (their attitudes towards something, for example) rather than to the differences in the situation of data collection" (Flick, 2007a, p. 43). Following a grounded theory paradigm, the researcher coded and categorized the data.

Coding and Organizing the Data

The researcher followed the process described by Strauss and Corbin (1990, 1998) for conducting data analysis using grounded theory. Early analysis involved synthesis and categorization of the data to identify patterns and common themes. This early analysis included rudimentary coding of the data units. Data units included words, phrases, and chunks of text from transcripts, field notes, and artifacts relating to a specific code. Defining the code and creating a decision rule provided consistency in the coding process. The decision rule explicitly stated the rationale for including a data unit in the code. It explained how to apply the code and what kinds of data to include (Gibbs, 2007). Data units were coded based on description or analytically. Analytic coding contained data units conveying the participant's thoughts and perceptions rather than purely offering descriptions of what occurred (Gibbs, 2007).

This study followed the process outlined by Harry et al. (2005) based on Strauss and Corbin (1998). Harry et al. delineate six levels of data analysis. Levels 1 and 2 pertain to *open coding* and *conceptual categories.* Open coding occurs when the text is read reflectively in order to discover categories and name their properties and dimensions (Gibbs, 2007; Neergaard & Ulhoi, 2007). During this process, the data were constantly compared with each other to determine which were similar along a particular characteristic and were grouped together into a specific code. Subsequent data collected

were compared to these codes and either grouped into these codes or new codes were created based on the emerging concepts. Twenty open codes resulted from this analysis step (see Appendix G). These open codes contained 1127 data units. See Appendix H for a breakdown of the number of data units by interview and code.

The researcher read each transcript electronically and highlighted the data units with the color corresponding to the code ascribed to the data unit. In addition to color-coding the transcript, the researcher created a Microsoft Word document entitled *Preliminary Data Codes.* This document included the data code, the code definition, and a table. The table for each code contained information on the interview number, page number from which the data unit was extracted, the data unit, and a section for researcher comments. As the researcher read each transcript and identified data units, these data were "cut and pasted" into this new document in the "Data" section for the appropriate code. The researcher completed this process for each of the 19 interviews, generating 120 pages of coded data. Each code started on a new page in the final document. The researcher then examined the data for theoretical issues underlying the text and recorded these concepts or themes in the comments section of the document. See Figure 1 below for an excerpt from Code 1 of this data analysis process.

Through the comparisons, the open codes were clustered according to conceptual categories in a process known as "axial coding" (Gibbs, 2007; Harry et al., 2005; Strauss & Corbin, 1998). Axial coding refers to the grouping of the codes around a common characteristic or concept. The relevance to which a category fits with the data is checked

Code 1: Behaviors Definition: This code contains descriptions of behaviors the Nursing Leaders indicate that they use to positively influencing staff retention.

Interview #	Page #	Data	Comments
1	1	"available to your staff; really accessible to your staff, even if they don't need you, they need to know that they could put their hands on you if they had to"	Accessibility Visibility
1	2 3	"And, you know, that I do, and then have to fight that battle on the other end." "I've been fighting that battle for over two years now, and haven't won yet."	Advocate for staff
1	2	"I do insist on professional behavior up here from everybody"	Accountability
2	1	"I guess sometimes just feeling like I can't always solve their problems, but I listen to them. So listening and being supportive, I think, are the two big things"	Communication-- Listen Supportive

Figure 1. Exert from Preliminary Data Codes Document. Comments include the researcher's interpretation of the data unit.

at this stage of analysis. For example, Codes 19 and 20 were grouped with Codes 10-14 pertaining to nursing leader preparation.

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According to Harry et al. (2005), Level 3 of data analysis involves developing central themes from the conceptual categories. This level parallels Strauss and Corbin's "selective coding" where central categories tie the subcategories, axial codes, together. These themes form the early foundation upon which to build a theory. Table 6

summarizes which codes the researcher grouped together by theme. This table also provides a summary of data units by theme.

Table 6. Summary of Codes & Data Units by Theme

Theme	Codes	Data Units
Organizational Culture & Policies	16-17	75
Nursing Leaders Training & Development	10-14, 19-20	342
Behaviors & Attitudes	1-2, 9, 18	380
Employee Factors	3-5, 15	198
Turnover	6-8	132

Level 4 analysis tested these themes. Testing occurred through comparison of new data to these themes. This data came in the form of subsequent interviews, focus groups, and artifact analysis.

Harry et al. (2005) entitle Level 5 analysis as *Interrelating the Explanations*. In this phase of the analysis, the researcher examined the data and themes for contradictions and discrepancies within and between categories and themes. In comparing across explanations, interrelationships between them emerged. The final level of analysis, *Delineating the Theory*, resulted in the creation of a substantive theory or model of Nursing Leadership and Staff Retention. Chapters 4 and 5 present the study findings and specific data leading to the model creation.

Although early grounded theory proponents describe it as being *data driven* (Glaser, 1992), more recent researchers and scholars acknowledge the difficulty in a complete *tabula rasa* approach (Gibbs, 2007; Harry et al., 2005) because of the influence of the researcher's previous experience in the field and exposure to previous literature on the subject of interest. Gibbs suggests moving to combining open coding with concept

driven coding in which codes come from the literature review, previous studies, topics in the interview guide, and researcher "hunches." For Gibbs, *concept-driven codes* describe topics of interest to the researcher. These codes differ from the Level 2 Conceptual Categories obtained from data analysis. Concept-driven coding forms a framework of analysis of key thematic concepts or ideas. Codes are then amended or added based on subsequent data collected. Concept-driven codes created at the outset of data analysis include codes for behaviors, attitudes, preparation, and employee satisfaction. For the purposes of this study, the researcher entered demographic and turnover rate data into a concept-driven coding system created in SPSS 14.0 based on the demographic information completed by the nursing leaders and the data provided by Human Resources. The demographic codes do not appear on the Code List. All codes on this list derived from the nursing leaders' perceptions offered during the interviews.

In qualitative research, data collection and analysis occur simultaneously. Early data analysis helped to redefine the interview questions with the expansion of additional probes into areas not previously explored. The interview guide was modified based on data collected and this early analysis process. In qualitative research, the researcher collects data until saturation occurs for the identified categories. Saturation occurs when no new information or data emerge from additional interviews. In this study, since all frontline nursing leaders were invited to participate, all those willing to be interviewed had the opportunity to participate even after saturation occurred. Saturation or redundancy occurred around the eighth interview. Once saturation was achieved, subsequent data collected was used to confirm the concepts and themes, thereby

increasing credibility of data interpretation. The next section of this chapter discusses credibility of the study.

Upon completion of the data collection phase, the researcher further refined and defined the coding of the data. See Appendix G for a complete listing of codes and definitions. After organizing the data in the *Preliminary Data Unit Code* document, the process of summarizing and interpreting the data allowed emerging themes to be articulated and supported by the data. Frequency of concepts was calculated from the "comments" section of the *Preliminary Data Unit Code* document. This information helped to guide interpretation of the data related to strength of importance. Data were compared on three levels: within a category, within a case (participant interview) and between participants (Flick, 2007a). Cross-group comparisons occurred related to unit turnover.

Ordering and structuring the categories facilitated comparisons. The themes obtained from the comparisons then became the basis for a model or theory of frontline nursing leaders and staff retention.

Interpretation of the Findings

The researcher interpreted the data within a systems theory conceptual framework. Systems theory views "organizations as open systems in active exchange with their surrounding environments" (French & Bell, 1995, p.89). Systems theory recognizes the interrelationship of people, structures, and processes, internally and externally to the organization or individual. French and Bell describe open systems as comprising of *input-throughput-output* mechanisms. *Inputs* influence the system in the

form of the external environment, people, information, and policies. *Throughputs* act on the inputs and create change in the inputs, resulting in *outputs. Outputs* are the end-products of these interactions. See Figure 2 for a diagrammatic representation of this theory. To this conceptual framework, the researcher added *Outcomes. Outcomes* provide tangible measurements of the Outputs.

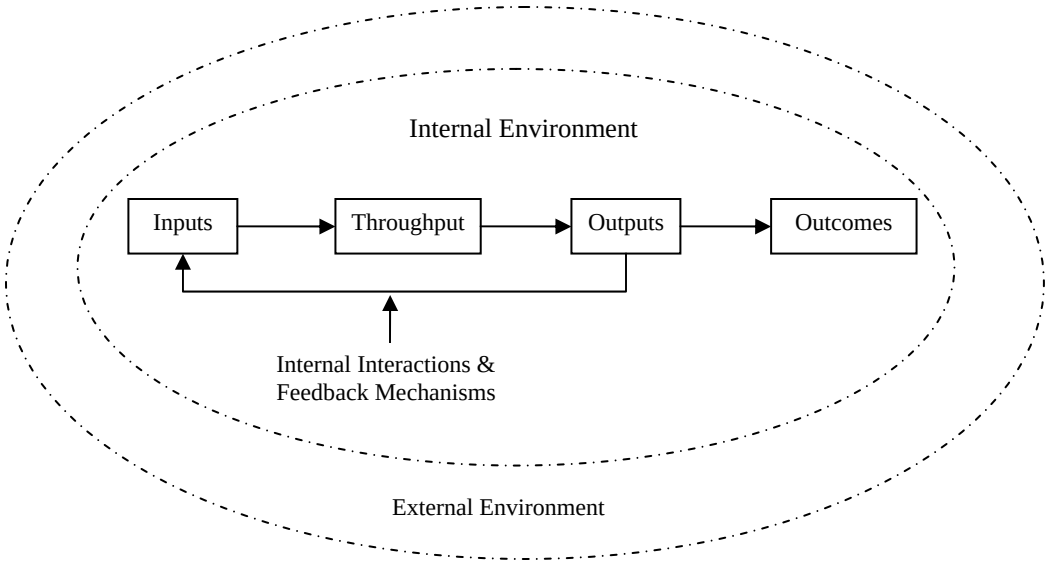

Figure 2. Systems Model. A system interacting with internal and external environment. Adapted from French and Bell (1995).

For this study, nursing leaders function as *inputs.* Two throughput themes emerged that influence and have the potential to create change in nursing leaders. These two themes, presented in Chapter 4 and discussed in Chapter 5, influence the behaviors and attitudes the nursing leaders exhibit, the *Outputs.* The results of the outputs can be benchmarked through measuring staff retention and turnover.

Systems theory does not assume a linear process. Multiple factors and variables act on the variables. In this case, the employee factors were considered and how these

factors are influenced by the nursing leaders' behaviors and attitudes. Per systems theory, a change in one part of the system leads to change in another part of the system. The researcher interpreted the data within this conceptual framework. Chapter 5 covers the interpretation of the data and provides discussion of the findings.

Validity and Credibility of Findings

In qualitative research, validity stems from agreement by the researcher and participants in the descriptions of the subject of interest. According to McMillan and Schumacher (2006), "Claims of validity rest on data collection and analysis techniques" (p. 324). They denote five essential strategies for enhancing validity in qualitative studies: prolonged field work, multi-methods, verbatim accounts, low-inference descriptions, and negative case studies. To these essential strategies, they add mechanically recorded data, member checking, participant review, and negative or discrepant data (actively searching for data that are the exception to emerging patterns).

All interviews and the focus group were digitally recorded. Verbatim transcription occurred from the recordings. The researcher listened to the recordings and compared to the typed transcript prior to sending the transcript to the participant. All interviewees validated the accuracy of the transcript with only three making alterations to the documents. The focus group participants all declined to receive a copy of the transcript for validation.

Strategies to increase validity in this study included multi-method strategies, interviews conducted in a naturalistic setting, mechanically recorded verbatim accounts, the use of direct quotations from data, and field notes with detailed descriptions of the

participants' verbal and nonverbal interactions. Field notes and coded transcripts are available for peer review and feedback, thus creating an audibility trail. These strategies also create transparency for how the researcher conducted the study and the process by which the conclusions were drawn from the findings (Flick, 2007b). The researcher also had prolonged and persistent field work by virtue of working in the facility where the study was conducted.

Reflexivity

The manner in which the researcher is intimately involved in qualitative data collection increases the potential for subjectivity and bias in both the data collection and the interpretation of the data (Gibbs, 2007). Awareness and attention to this fact, and the use of reflexivity, increases the validity and credibility of the findings. McMillan and Schumacher (2006) define *reflexivity* as "a broad concept that includes rigorous examination of one's personal and theoretical commitments to see how they serve as resources for selecting a qualitative approach, framing the research problem, generating particular data, relating to participants, and developing specific interpretations" (p. 327). Reflexivity involves critical reflection on how the researcher, participants, and the phenomenon of interest interact and influence each other (Corbin & Strauss, 2007; Glesine, 2006). The researcher undergoes rigorous self-scrutiny during all phases and aspects of the research process.

Numerous strategies exist to enhance reflexivity and transparency. In this study, the researcher primarily used a field log and field notes journal. Transparency begins with detailed documentation of the research process, including the steps taken along the way

and factors influencing decisions (Flick, 2007b). The field log delineates dates, times, places, individuals, and activities for data collection. This log also includes comments about these activities and decisions. The field notes journal also chronicles the decisions made throughout the study and the rationale influencing these decisions. This process creates a decision trail that can be used for audibility purposes. Also recorded in the journal were inferences drawn from the data. The field journal includes ethical deliberations, how any dilemmas were addressed, and the researcher's critical self-monitoring process. For example, the nursing leader who did not participate in the interview process offered to participate in a focus group. After reflection and discussion with the study advisors, the decision to exclude her from the focus group occurred in order to keep the participants consistent with the interview process. In recording these elements in a journal, the researcher underwent critical self-monitoring, which aided in identifying potential biases (McMillan & Schumacher, 2006).

Interpersonal Subjectivity

In addition to the researcher's inclinations about the competencies of frontline nursing leaders that influence staff retention, the researcher brought her previous experiences as a frontline nursing leader and previous observations and assumptions of the role. It is naïve to believe that these preconceived ideas and experiences do not have bearing on the collection and interpretation of the data. Glesine (2006) suggests recognizing and monitoring subjectivity in order to enhance trustworthiness of the study. Efforts at transparency in the data analysis "are supported by prolonged engagement in the field and by testing the emerging interpretation against participants' perspectives, a

process sometimes referred to as ‘member checking’” (Harry et al., 2005, p. 7). Member checking was done during in the interview process by rephrasing and verification of understanding (Kvale, 2007) thus allowing participants the opportunity to immediately correct misperceptions or misunderstanding on the part of the researcher. Member checking increases the quality and validity of the interpretation of the data (Flick, 2007a; 2007b).

The researcher must differentiate participant perception from personal perception and bias. Critical self-monitoring increases the researcher’s awareness of personal subjectivity that seeps into the data analysis and aids in refocusing back on the participants to learn their perceptions. Peshkin (2000) argues, “An important reason for reflecting on the development of an interpretation is to show the way a researcher’s self, or identity in a situation, intertwines with his or her understanding of the object of the investigation” (p. 5). This understanding or interpretation of the situation factors into inductive data analysis.

Use of critical self-monitoring and reflexivity strategies by the researcher enhanced validity and credibility of the findings. Given the intrusive nature of qualitative research, attention was given to ethical concerns. The next section discusses potential ethical situations that might surface in this study and how the researcher addressed these concerns.

Ethics

In establishing an ethical qualitative research design, Orb et al. (2001) delineate three essential principles, autonomy, beneficence, and justice, based on the early work of

Capron (1989). Autonomy involves a person's right to voluntarily choose to participate in the study free of coercion and the right to withdraw from the study at any time. Informed consent provided potential participants with information necessary to make their decision by delineating the purpose of the study and any potential risks to the participant (Kvale, 2007). The researcher gave participants in this study verbal and written information about the goals of the study and how the data would be managed, analyzed, and how the findings would be used. Participants were asked to give both verbal and written consent. A copy of the informed consent is located in Appendix D.

Informing the participant of potential risks aligns with the principle of beneficence, which entails the prevention of harm in the process of doing good. Researchers have a fiduciary responsibility to protect the participants (Flick, 2007a; Orb et al., 2001). Multiple strategies were used to protect the identity of the participants. Demographic information was not included on the recorded interviews. The researcher gathered this information on a separate document for tabulation and comparison. The digital recordings were saved simply as "VCU no.__" and the transcripts were identified as "Interview no. __." Additionally, the digital recordings and transcripts were stored in a secure place in which only the researcher had access.

The use of pseudonyms helps protect participants' identities (Orb et al, 2001) both in the dissertation and in publications. Only the researcher knows the identity of the interviewee in relation to the interview number. Unique identifiers were not used when reporting the data. Since the study participants only included two male nursing leaders,

the findings do not attribute any direct quotes to the male gender. Because 17 females participated, the pronoun “she” is used.

Orb et al. (2001) recommend informing participants on how the results will be published and having participants approve direct quotes in publications. Participants were given the opportunity to review the transcripts and strike any quote from it prior to inclusion in data analysis. One participant requested to review direct quotes from her transcript prior to publication in this study or future publications. This nursing leader approved all quotes attributed to her for this study. In addition to these steps to protect the identity of the participants, when quotes were used in reporting the findings in Chapter 4, all references to a specific unit were removed and replaced with the generic word “unit.” Written documents with participant identifiers on them no longer required for the study will be shredded before disposal. Field notes and the field journal will also be kept secured and only be shared for audibility purposes.

The third ethical principle proposed by Orb et al (2001) involves justice. Justice describes the equal and fair treatment of participants. This principle ties into the autonomy principle. Recognizing the vulnerability of participants, the researcher has an ethical obligation to avoid exploiting or abusing the trust granted to her by the participants. Because the researcher was known to the participants, there existed the potential for participants to feel obligated to participate in the study. To address this concern, the researcher provided information on the value of the study to the participants, the organization, and to nursing leadership research. In addition, the researcher requested an outside person contact study participants after the interview to ascertain their level of

comfort with the interview process. The following questions assessed the interview process:

1. Did you voluntarily participate in this study?
2. Did you, at any point, feel any pressure to participate in the study?
3. Would you like to have your interview data withdrawn from the study?
4. Do you have any comments that you would like to make about the recruiting process for the study or the interview itself?

The caller gave the leaders the option to have the data withdrawn from the study. All nursing leaders indicated voluntary participation and a desire to have their data included in the study. The nursing leaders spoke positively of the experience.

In addition to the above-mentioned strategies to protect participants and ensure high ethical standards, Institutional Review Board (IRB) approval was obtained from Virginia Commonwealth University and the facility where the study was conducted. Application and approval to conduct the study was obtained in compliance of the rules and regulations of both organizations prior to data collection from human subjects (see Appendix __). At the request of the study site IRB, the researcher faxed copies of all consent forms to their office.

Delimitations of the Study

The goal of this study was to create a substantive theory on the perceptions of frontline nursing leaders on behaviors and attitudes influencing staff retention. The narrowness of the intended target population limits generalization to other levels of nursing leadership. Despite this limitation, this information will be useful to academic and healthcare organizations for program planning. Comparison of the frontline nursing

leader model to the nurse executive model shows areas of similarity for these groups to target future education.

A second limitation pertains to the narrowness of the focus. This study concentrated on the competencies, behaviors, and attitudes of frontline nursing leaders that they believe aid in retaining staff. While helpful for training and education, the study does not provide sufficient data to develop a comprehensive nursing leadership curriculum.

Because the researcher is an inside observer, there exists the potential that frontline nursing leaders behaved differently around the researcher. This limitation should be relatively minimal given the tenure the researcher has in the organization and a pre-existing and long-standing rapport with the frontline nursing leaders (Glesine, 2006).

A fourth limitation relates to the participants and the site of the study. The participants were from a single, community, acute healthcare organization in central Virginia. The competencies identified by these community hospital frontline nursing leaders may vary from that of a frontline nursing leader employed in an academic or long-term care facility. Generalization to other parts of the U.S. and abroad may be limited.

A final limitation pertains to the fact that the study only explored the perceptions of frontline nursing leaders. The study did not assess nursing staff or Human Resource staff perceptions. This study sought to generate a theory or model of frontline nursing leadership perceptions of behaviors and attitudes related to staff retention within a specific context and construct. The rigor with which the researcher conducted this study

lends the findings to the potential for generalization. Generalization will need to be done by individual readers by assessing similarities with their situations.

Conclusion

This chapter delineated the process by which the researcher conducted the study. Using grounded theory firmly embeds the data into the theoretical framework generated. Following the paradigm of Strauss and Corbin (1998) outlined by Harry et al. (2005) calls for identification of data units and placing them into *open codes*. The categories of codes initially created were then formed into *axial codes* in which subcategories converged around the axis of a single category. The third step entailed the creation of *selective coding*, in which the subcategories were arranged around central categories supporting a coherent framework. Themes were derived from interpretations of the data collected through interviews, a focus group, and documents reviewed. Throughout the data collection and analysis process, emerging data guided decisions about further data collection and ways to test the emerging themes, leading to generation of a substantive theory. To increase credibility and validity of the findings, the researcher used extensive field notes and journaling to practice reflexivity and critical self-monitoring. Potential ethical concerns were addressed throughout the study as they arose. IRB approval from Virginia Commonwealth University and the study site were obtained prior to data collection from human subjects. This chapter addressed procedures for carrying out the study. Chapter 4 presents the findings of the study.

Chapter 4 Findings

Introduction

The researcher conducted this study for the purpose of identifying, describing, and analyzing the perceptions of frontline nursing leaders of behaviors and attitudes that influence staff retention. The researcher also desired to learn the extent to which nursing leaders felt current leadership education and training programs support their practices that promote staff retention. The goal of the study was to create a theory or model of nursing leadership and staff retention grounded in the data.

In this chapter, the researcher reports the findings of the interviews, data from artifact review, and results of the focus group. According to Glatthorn and Joyner (2005), the researcher reserves perceptions and interpretation of the findings for the discussion in Chapter 5. Chapter 5 discusses the interrelationship of the themes in forming a descriptive model of nursing leadership and staff retention. In qualitative research, no specific rules exist for reporting the findings (Bogdan & Biklen, 2007; Glesine, 2006). While a variety of text organization strategies exists, the most commonly used technique involves organization by themes or topics (Glesine, 2006).

Chapter 3 methodically described the data reduction process using constant comparative analysis for grounded theory. The findings presented in this chapter result

from the content analysis of the nineteen interviews. Data gathered from artifacts support and enhance these findings. This chapter presents the main categories and themes that emerged for each research question using this process. Key concepts within the categories are examined, defined, and substantiated by the data. Chapter 4 begins with a description of the context in which the researcher conducted the study to provide the reader with a frame of reference.

Context

The mission statement for the facility where the study took place is *Improving life through comprehensive healthcare.* This medical center encompasses two campuses located approximately 7 miles apart with 758 patient care beds. One campus houses a Heart Hospital where the most heart catheterizations and cardiac interventions are performed annually for the Central Virginia region. This campus also provides psychiatric services. The second campus is best known for its excellence in Neuroscience, cancer, and rehabilitation services. Both campuses provide the community with Obstetrics, Emergency Care, and Surgical Services. The medical center boasts of numerous specialty certifications and awards on its website. HealthGrades awarded the medical center the distinction of “America’s 50 Best Hospitals” for two consecutive years. *Working Mother Magazine* named the medical center as a “2008 Working Mother 100 Best Companies” for the third consecutive year.

The medical center employs roughly 3,200 people of which approximately 1,250 are Registered nurses (RN). Nursing retention begins with recruitment. In attracting and recruiting nurses to this facility, its website states,

> We love to see our nurses succeed. We've made it a priority to provide the specialized training and supportive environment you need to grow in your career. From a direct line of communication with management to a wide-range of educational opportunities, we've got it set up to help you get even better at what you do best and move up the ladder while you're at it!

The facility supports this statement by employing seven clinical nurse educators for the various specialty areas. The researcher for this study currently works for the facility providing education to staff employed in areas that care for critically ill patients.

The website for this facility also lists available positions for which prospective employees may apply. The nurse recruiter screens the applications and then forwards them to the nursing leader for the department in which the person is interested in working. The nursing leader then contacts and interviews the person. After the interview, the director notifies the Human Resource Department regarding whether or not to extend an offer for employment. If the person accepts the offer and successfully completes the employment process, the nurse's orientation to the hospital and the unit begins.

Findings: A Descriptive-Narration

In looking to find meaning and emerging themes from the data, the researcher carefully listened to the interview recordings for content meaning as well as changes in intonation and pauses. The researcher incorporated these data into the field notes after the interviews. Using Microsoft Word processing, the researcher color-coded key words, phrases, and sentences in the interview transcripts during the open coding phase. The nineteen interviews yielded 1127 individual data units from this data analysis process (see Appendix H). The axial or selective coding of the data resulted in five categories or themes from the initial twenty individual codes. The twenty open codes evolved from the

data collected in the interviews (see Appendix G). Table 6 depicts the relationship of the codes to the themes identified.

Table 6. Summary of Codes & Data Units by Theme

Theme	Codes	Data Units
Organizational Culture & Policies	16-17	75
Nursing Leaders Training & Development	10-14, 19-20	342
Behaviors & Attitudes	1-2, 9, 18	380
Employee Factors	3-5, 15	198
Turnover	6-8	132

The researcher then computed the frequency with which the nursing leaders mentioned key concepts within each of the categories or themes. Calculating the frequency with which the nursing leaders mentioned a concept lends credence to its relative importance. This process was done by using the information in the comments section of the *Preliminary Data Coding* document in which the researcher labeled the data unit based on the concept represented. The next section expounds on specific findings.

Emerging Themes

Five major themes emerged from the interview data analysis process. These themes include organizational culture and policies, nursing leaders training and development, behaviors and attitudes, employee factors, and turnover. Table 7 depicts the major categories and subcategories that emerged from this data. The next section provides details and supporting data for each of the emerging themes in relation to the research question.

Table 7. Themes & Subcategories Emerging from Data

Organizational Culture & Policies	
	Productivity, Staffing Ratios
	Culture of Accountability
	Administrative Support
	Administrative Follow-through & Follow-up
Nursing Leader Training & Development	
	Preparation for the Nursing Leader Position
	Factors influencing level of comfort with nursing leadership position
	Level of Education Recommended
Behaviors and Attitudes	
	Administrative Domain
	Professional Domain
Employee Factors	
	Job Satisfaction
	Family/Life Circumstances
	Educational Development
	Career Development
Turnover	
	Reasons for turnover
	"Positive" turnover

Research Question 1

Behaviors and Attitudes

The central question this study sought to answer pertained to frontline nursing leaders' perceptions of behaviors and attitudes that contribute to staff retention. In

answering this question, the researcher focused on data obtained from the following interview questions:

1. How do you think you, as the director of this unit, influence retention of staff?
    a. Describe the behaviors you believe nursing unit directors must exhibit that promote staff retention.
    b. What attitudes do you feel nursing leaders should have in order enhance staff retention?
    c. Which of these behaviors and attitudes do you feel you exhibit most frequently?
2. If you could make one change to impact retention, what would you do?

Probing questions varied depending on the responses generated from the primary question. The data obtained from these questions predominantly were coded into codes 1, 2, 9, and 18. Code 1 included data in which the nursing leader described behaviors that facilitate staff retention. Code 2 included data regarding attitudes the nursing leaders perceived as aiding in staff retention. Code 9 data resulted from the question, “If you could make one change to impact retention, what would you do?” Finally, Code 18 contains data related to tips the nursing leaders offered for specific behaviors and attitudes contributing to staff retention. Data units from these three codes comprised 380 of the 1127 data units (approximately 34%). Figure 3 illustrates the two subcategory domains that emerged from the data. These subcategories each contain specific behaviors and attitudes voiced by the nursing leaders that they perceive influence staff retention. While the nursing leaders mentioned a large variety of behaviors and attitudes, the subcategories contain the most frequently mentioned ones. It is not meant to be an all-inclusive list. Supporting data for each domain follows Figure 3.

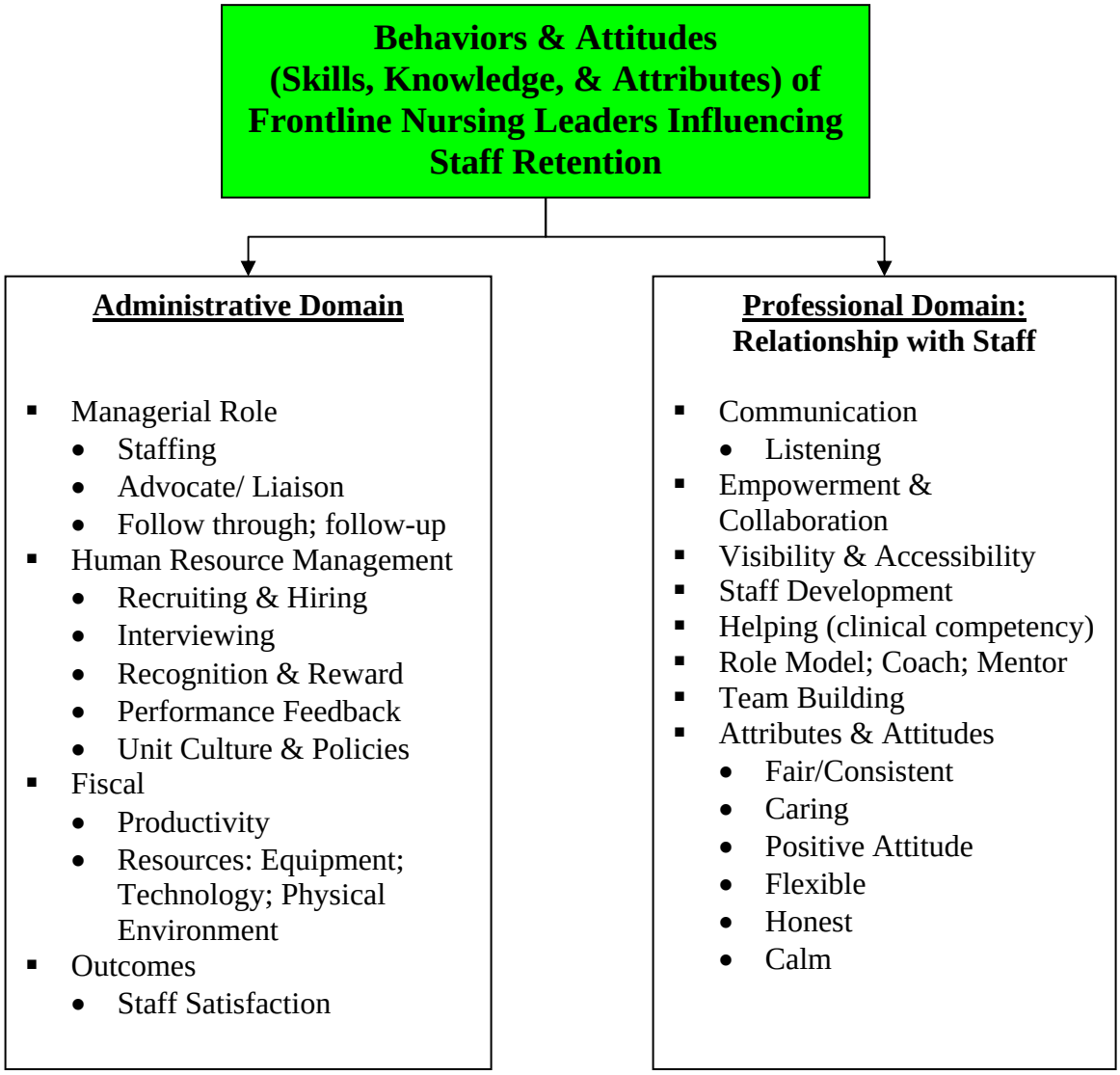

Figure 3. Behaviors & attitudes identified by frontline nursing leaders that influence staff retention.

In this section, the researcher presents data from the interviews on behaviors and attitudes nursing leaders perceive as influencing staff retention. Axial or selective coding sorted the data into two subcategories, administrative and professional. The administrative category contains behaviors nursing leaders exhibit in order to maintain day-to-day functioning of the unit. The professional domain encompasses what is often

called the “soft skills” or relational skills. Since the largest number of behaviors and attitudes emerging from the data fell into the professional domain, discussion begins with these concepts.

Professional domain: Relationship with staff.

Data on how nursing leaders treat their staff fell into the professional domain subcategory. As one nursing leader described it, “It’s basic people skills, and you need to have basic people skills to be in any management role” (NL#2). Many of the nursing leaders emphasized the importance of knowing your staff on a personal level. They offered examples of learning about their families, what significant events are happening in their lives, and being open and approachable. Nursing Leader #4 offered this insight: “They need to feel like they can come and talk to you, and they also need to know that they're not out there alone when it gets really bad, because if they're continually stressed when they're coming to work, they're not going to continue to do that for long.”

Communication and Listening

The most frequently mentioned competency nursing leaders mentioned pertained to communication. Elements related to communication were mentioned 33 times in Code 1. Listening skills surfaced as the most important element of communication identified by the participants. In response to the interview question, “How do you think you, as the director of this unit, influence retention of staff?” one nursing leader stated,

> By listening to what I feel the employees want, and trying to build relationships with the staff and encouraging my management team to build relationships with the staff, so that you have an understanding of who may be upset or on the fence of thinking about leaving and why (NL #6).

In addition to listening, acting upon the suggestions aids in making the staff feel valued. Nursing Leader #17 states she "listens to them, and when they have suggestions, [she takes] them forward." To facilitate communication, the nursing leaders frequently spoke of having an "open door policy." They encouraged staff to voice concerns directly to the nursing leader. In response to multiple interruptions by the staff during an interview conducted in a nursing leader's office, the nursing leader responded,

> Well, they know I have an open-door policy, and they know they can come in and they can sit down, and they can vent. They can tell me their concerns. If they just need to come in here and just take a deep breath, they know that what's said in here stays in here. And, I think they have realized that they have my trust and my confidence, and they know that. That's why that door stays open, but that's what I want because I don't want them to stand out there and have, be struggling or having a terrible day or having an issue with a patient or something and just hold it in, hold it in. I would rather they come in and tell me and say, "This is what's going on" and then they get it off their chest. I give them feedback on what I think, and they usually go out of here smiling. So it gives them a chance to vent.

Visibility and Accessibility

Tangent to communication skills and an open door policy, the nursing leaders felt strongly that they need to be "visible" and "accessible" to the staff. Code 1 contained 21 data units related to this concept. The nursing leaders voiced the challenge of meeting this competency given the multiple demands of their role and the frequency of meetings. In speaking about visibility and accessibility, Nursing Leader #18 indicated, "[I make] myself available to them, giving them the opportunity for feedback. I spend a lot of time out in the environment so that they have to opportunity to interface with me, so I kind of have a feel for what's going on out there." Nursing Leader #15 echoed these sentiments in saying, "Visibility [of the nursing leader] shows the staff that you're around for them, that you are accountable to them."

Role Model

Being visible allowed the nursing leaders to serve as role models to the staff related to professional expectations. Nursing Leader #10 pointedly stated, “You have to model the behavior that you wish your staff to have.” Ten of the nursing leaders spoke about the importance of leading by example. Leading by example “builds trust and respect that speaks louder than any words can” (NL#16). Nursing Leader #19 described it as,

> I've always led by example. And, I feel like this is a huge component. I usually don’t ask anybody to do something that I don’t do myself. Always being consistent, and I feel like more people are apt to do things for me or work extra shifts because I'm always out there with them, and I guess, leading by example, that’s my big thing.

Helping and Clinical Competence

They frequently described situations of “actually getting out there, kind of in the trenches with the troops and getting in the mud and the muck” (NL#4). Clinical competency arose in nine of the interviews. These nursing leaders felt that remaining clinically competent increases their credibility with the staff and creates a positive influence on the staff. Nursing Leader #18 stated, “I have no problem picking up a mop or whatever. Staff see me doing that and it’s amazing the change that happened.” In demonstrating willingness to help and clinical competence, the nursing leader “gained their confidence” (NL#18). Nursing Leader #15 supported this stance in saying, “I had a nurse from a different unit tell me that I'm not afraid of getting my hands dirty. And that gives me respect from my staff; that they know that I'm not asking them to do a job that I don’t do myself.” Due to the unit structure, one nursing leader lamented not maintaining

clinical competency. She stated, “I'm not involved in the clinical aspect at all anymore. [Today,] I did nothing but find staff to work in that unit” (NL#17). The demands of the nursing leader role inhibit her ability to work in the unit in a patient care capacity. She relies on her shift managers, the clinical coordinators, for clinical issues.

Empowerment

Staff involvement in running the unit rose multiple times as a retention strategy. Thirteen nursing leaders described empowerment behaviors. These nursing leaders have incorporated elements of shared governance on the unit and increased the ways in which staff have voice. Increasing staff involvement in running the unit has given the staff “buy-in, and let them have a stake in the unit” (NL#3). This investment by the staff in the unit results in improved retention according to Nursing Leader #4:

> It’s not a dictatorship. Can’t come in and bust the door down and go ‘Sheriff’s in town, and this is the way the town’s going to run.’ You can’t do that. And, that also leads back to retention. If you’re constantly trying to swim upstream, eventually you're going to lose your team.

The nursing leaders described multiple ways in which they promote staff involvement in unit functions. Some leaders encourage staff input into hiring decisions. Many nursing leaders allow the staff to do self-scheduling and have staff offer input into patient assignments. In one unit, the nursing leader encourages staff to utilize their talents for the benefit of the unit. She indicates, “…everybody [has] talents. We try to give everybody a job, and try to let everybody have a role in how the unit is run” (NL #6). Nursing leaders also involve staff in problem solving. When faced with a unit issue, Nursing Leader #9 presents it to the staff and says, “‘Well, we've got this problem. What can we do to resolve this, and I want everybody’s input.’” The nursing leaders felt that

empowering the staff to make decisions and providing an avenue to offer input influences staff satisfaction and, ultimately, staff retention.

Staff Development

The nursing leaders identified education and training on their unit as a mechanism for increasing staff satisfaction and improving the quality of nursing care on the unit. Nine of the interviewees discussed the importance of this concept. Two aspects of this concept emerged. In some situations, the nursing leader promoted education and training as a means of staff retention for the facility, but not necessarily for the unit. A nursing leader of a Medical-Surgical unit described how she helped to transition her nurse to the Intensive Care Unit. “I prevented her from walking out the door by giving her the opportunity of advancement in her clinical skills” (NL #2). The Medical-Surgical and intermediate care unit nursing leaders talked about these units serving as training grounds for the Intensive Care Units (ICUs) for staff. When staff voice a desire to move to a higher level of care, these nursing leaders try to facilitate an internal transfer.

The second aspect of this concept involves promoting education and training with improving patient care and staff satisfaction as the intent. In promoting staff development, Nursing Leader #5 indicated, “My job is to help them achieve what their goals are, which is quality patient care, and working and building those professional boundaries that they have to develop over their careers.” Quality patient care comes with increased knowledge and skills. Promoting staff development increases staff satisfaction and involvement in the unit according to Nursing Leader #9 who said, “I'm actually pushing and picking out people just to have more education, and I think they really

appreciate it and some of them have gotten really involved and really excited. I think it's really picked up, their enthusiasm about what they do." She went on to support this statement by saying, "I think staff education is something that helps in retention because they feel like they're being kept up and given the opportunity to learn and share that with the staff, during staff meetings, during in-services for the staff, bringing the stuff they learn back to the unit. I think it would give some a good bit of self-confidence and makes them feel like they're participating in the function of the unit."

As a means of staff retention and staff satisfaction, one nursing leader indicated she focused on making certain the new hires have an adequate orientation. She states, "I make sure they get a thorough orientation; keep adding to what they're doing so they're continually learning something new. And trying to get them to where they want to be" (NL #3).

Attributes

What undergirds interpersonal relationships are the personal attributes and attitudes the nursing leaders feel are important to exhibit. Code 2 yielded an abundance of data units related to this theme. Six primary concepts related to attributes emerged from the interview data. These concepts, in order of prevalence, include fair/consistent, caring, positive attitude, flexible, honest, and calm. Nursing leaders overwhelmingly felt that being fair and consistent was the most import behavior or attitude that influenced staff retention. Comments included:

- Just by trying to treat people the right way, trying to do the right thing all the time, and be understanding of the situations that they have, but also being fair as well (NL#1).

- Unbiased, nonjudgmental, I mean, you truly have to be open to all different types of people and personalities; recognize that every individual is unique in their own, and to honor and respect that; you have to really be open to the different cultures and the different personalities (NL#4).
- [Being fair is] important to me. I treat everybody the same, regardless. And I think staff watch that and that's important to them. And that builds respect. I'd rather be respected than liked because that's something that I value (NL#16).

The next most frequently mentioned attribute or attitude was caring. The nursing leaders offered numerous examples in which they demonstrate caring and compassion. Statements reflecting this concept include:

- They just want you to realize they're a person, realize what their needs are (NL#5).
- Show that you care about them as individuals, as professionals, to listen to their needs, each one of them I think are so unique. Some of them like education, some like having their time off, and people laugh at me with the X and Y generation and all that, but that's a challenge for me, understanding the needs of the younger nurses. But the main thing is just treating them as individuals, I mean, that's what I was looking for, recognizing their strengths, trying to help them through their, what we identify as their needs (NL#12).
- I feel like I'm very compassionate. I know I'm not the real fuzzy, fuzzy, fluff and puff type of person, but I think that they can see that I genuinely care about them as individuals (NL#13).

After caring, the next frequently mentioned attribute was a positive attitude. The nursing leaders talked about putting a "positive spin" on information when communicating potentially unpleasant messages to the staff or in times of adverse conditions. As Nursing Leader #2 stated, "I take every day on as 'we're going to succeed. We're going to get through this day no matter what.' So the attitude of just being positive and we can do this." Another nursing leader echoed these sentiments in stating,

> You have to be positive. I don't think that you have to hide or falsify information to your staff, but there's certainly a way to present information that, even though you may be delivering tough information or an unpopular decision, presenting it with a positive attitude. Or, asking for their input, I've learned over the years helps instead of just giving

> information as a mandate or an edict. Some things, some information is just information, but there are other things that you can get their input which helps them buy into whatever it is that you're trying to do (NL#14).

Helping the staff to see the positive of a situation threaded through the nursing leaders' comments regarding this concept.

The nursing leaders offered numerous examples when discussing flexibility as an attitude influencing staff retention. They suggested flexibility in staff schedules and assignments. In particular, several nursing leaders acknowledged the influence of their aging staff on how the unit functions with regard to scheduling. Nursing Leader #1 stated, "[There is] an older nursing population up here, the average age is about 53, and so not only are nurses dealing with their aged parents, they're dealing with issues that their children are having dealing with grandchildren." In addition to needing flexibility related to scheduling, nursing leaders voiced the need for flexibility in relation to being open to change. As Nursing Leader #8 said, you have to be flexible "as far as just having to change gears, depending on what's going on in the [unit]." The nature of healthcare makes the work environment unpredictable and in constant flux relate to patient census and staff availability. The nursing shortage necessitates a degree of flexibility in order to remain competitive with other healthcare organizations. Nursing Leader #5 phrased it this way, "With the nursing staffing situation the way it is now, and most likely it's probably going to get a lot worse a lot faster, you have to be willing to adapt."

In addition to the above-mentioned attitudes and attributes, the nursing leaders also suggested honesty and calmness as desirable traits that promote staff retention. Modeling

these attributes for the staff promotes trust and confidence in the nursing leader. In an environment of trust, staff are more likely to stay.

The nursing leaders discussed many interpersonal relational behaviors influencing staff retention. They also discussed creating a healthy work environment. The next section covers ways in which the nursing leaders feel they accomplish this objective.

Administrative domain.

In this domain, the nursing leaders described a multitude of behaviors that pertain predominantly to the management of the unit. This domain encompasses management of the physical environment in addition to human resource management (HRM). The leaders felt that the physical environment as well as how the unit was managed influenced staff retention.

Human Resource Management (HRM)

From a HRM perspective, numerous nursing leaders spoke to building the right team—both management and staff. They called it “hiring well.” Many nursing leaders voiced the importance of developing a relationship with Human Resources in order to clearly communicate what needs exist for the unit and to obtain applications for potential employees. As part of this process, one nursing leader stated her role in “continuing to recruit really good people; fine tuning my interviewing skills to try to recognize those that are going to be a great fit and those that may not be. You just can’t hire a body. Sometimes you're really going to have to suffer through your staffing shortage to make sure that you're hiring the right people to retain them” (NL#4).

Nursing Leader #8 described the significance of the leadership team this way:

> I also believe that it's important to hire good leadership as well as staff RNs and techs. But the leadership team is as important as almost anything in the [unit] as far as retention goes. The leadership team has to be cohesive. They have to work well together. They have to communicate well together. They have to have the respect of the staff. And, we, as a leadership team, need to respect each other and be on the same page when it comes to decisions and ideas. So, if you have someone that for whatever reason doesn't fit in, it's, the staff then struggles because they get mixed messages, or they see different leadership styles and then it really, I think that's frustrating to staff.

This nursing leader related how one staff member who also works for a competing hospital told her she that what she liked about this facility was that each time she came back, she knew she "would have the same bosses." In addition to choosing the unit leadership team wisely, the nursing leaders addressed hiring the "right fit" for staff. One leader described a critical staffing shortage on her unit when she moved into the leadership role. She chronicled her change in hiring practices from that time to now.

> If you see this one application, is this person really a fit for this unit? And there are times where I felt like I was, "okay, here's a nurse that wants to come here, do I take her even though I know that she's not really a good fit because I need the staff, or do I hold out and get the people that I really think they're made for this unit?" And, I can tell you when I first came here, I took staff because they were a body. Now, I've grown a little I think, and I'm not doing that any more. Because you don't retain those people. If something is telling me that this isn't going to be a good fit, then most of the time, I'm not bringing them on as readily as I was before (NL#13).

Another nursing leader, faced with a similar situation upon her hire, relayed, "They had had a lot of turnover in [the unit] before I got here. And I worked really hard to fill positions, not just with people that are going to be clinically competent, but people that I feel will be a good personality fit in the unit" (NL#14). From a quality standpoint, Nursing Leader #19 stated, "I feel like making the person the right fit is the best thing for

that person, the staff, and the patients involved." To assist in finding people who are the right fit, several nursing leaders described involving the staff in the hiring process. Nursing Leader #16 articulated her hiring process this way:

> You recruit the right people, that you put time and effort in doing that to get the right match for a particular area. I really try to involve staff when I am recruiting for a position because I believe that having their buy-in in the individual and support of individual is important as well. I think the more people you involve in the interview process, you can pick up if it's going to be a good fit for both as well. So sometimes I may not pick up on something that staff may. I also think it's important that they hear how you run things and get a true assessment of the leadership structure, and I think staff are the best to give that to perspective candidate, because I think you want to be very truthful and honest about your areas in the leadership structure, and I think if you do those things upfront, you're more apt to get the right fit and match for the unit and have someone that's going to be for a long period of time.

Unit Culture and Policies

In creating the right team, the role of accountability surfaced in multiple dimensions. Not only do nursing leaders feel accountable to their staff, they spoke frequently of holding staff accountable for professional behavior and how doing so contributes to staff retention. Nursing Leader #16 stated,

> If you say to them, 'I'm building this culture of accountability here, I'm going to be visible, I'm going to be responsive,' then to retain them, those things need to happen, they need to see those things.

This behavior manifests itself in the development of unit culture and policies governing how the unit runs and in unit norms and values. The nursing leader oversees the creation and maintenance of unit culture through enforcement of policies. The nursing leaders described increased staff satisfaction when the nursing leaders demonstrated consistency and fairness in holding all staff to the same standards of professionalism. For example,

Nursing Leader #6 stated, “Everybody’s watching what you're doing. So it’s a staff satisfier for the staff to see that you're dealing with a difficult employee.” In describing how fairness and equity influence professionalism and staff retention, Nursing Leader #14 stated,

> If your staff sees that you're treating everybody the same for issues like scheduling, or patient care issues, or enforcement of even policies or [population specific] safety initiatives, if it applies to everybody and it applies the same way, I think people appreciate that. That there’s not favoritism.

To help staff develop professional behavior and learn expectations, one nursing leader worked with the facility’s Organizational Development department to improve upon “customer service that they know there are certain attitudes and behaviors that are not accepted on this floor any more. There’s a certain standard, certain behavior that’s expected of every person on this floor and they're held accountable for it.”

Recognition and Reward

While creating a culture of accountability surfaced as important, the nursing leaders also felt recognizing and rewarding the staff plays an important role in staff retention. In addition to asking questions specific to nursing leadership behaviors and attitudes, the researcher asked the nursing leaders, “If you could make one change to impact retention, what would you do?” The top responses to this question related to rewarding and recognizing staff and improving staff or staffing ratios. Nursing leaders suggested recognition be in the form of implementing “a patient-nurse, a patient’s choice award recipient, on an annual basis” (NL #5), communicating that the staff are valued

and appreciated for their hard work, and helping staff achieve and maintain professional certifications. The nursing leaders offered many examples of how they recognize staff:

- When our patient satisfaction scores come back, and we do make a big to do about that, we post it on the board, and send emails (NL#1).
- I get the treasure chocolate bars and I write, Thank you, you're a treasure and stick them in there or you're life saver and stick a Life Saver in there (NL#3)
- Pay attention to the high performers and praise them even in little ways whether it's praising them in front of a group or at staff meetings or emails when somebody does something good, that kind of pulls the group up (NL#6).
- If people meet 100% [on the pain audits], we'll give out meal tickets sometimes, or send out an email listing out the people that have done very well (NL#7).

Nursing Leader #9 related how she noted a change in her staff after she became the director and started recognizing the staff. She states,

> I've seen attitudes change. I've seen people who would come in and do their eight-hour shift and leave and not volunteer to help, now willing to help when someone calls in sick or volunteer to stay. 'I can stay those four hours if you need me.' I think the recognition and knowing that what they do is appreciated, that they have come around and really developed teamwork and are taking more pride in what they do.

When discussing rewards for staff, nursing leaders felt that tenured staff need acknowledging. A nursing leader indicated,

> I would do something for the nurses that have been here longer. I feel like, I do feel like the cap for the RNs that have been here for the longest, is too low and getting a bonus every year, it just doesn't make them happy. The nurses that are my strongest nurses have been here a long time and to do something to retain the long-time staff would be my biggest thing that I would want to do. (NL#15)

For this nursing leader, 50-60% of her staff fall into this long-term employee category. Another nursing leader suggested rewarding staff for perfect attendance, e.g. no "call-

ins," for six or twelve month period with an extra Paid Time Off (PTO) day per year. Nursing leaders voiced frustration over the time it takes to find additional staff when employees call-in for a scheduled shift.

Advocate/Liaison

In addition to the aforementioned administrative behaviors promoting staff retention, the nursing leaders mentioned the importance of advocating for staff and serving as a liaison between the staff and senior administration. The nursing leaders described a wide variety of situations in which they acted as intermediaries between the staff and administration. These situations included working to improve staffing ratios, obtain equipment, improve technological support, raise salaries, and facilitate proper patient placement. Nursing Leader #16 summarized it this way,

> [Nursing Leaders] represent the staff needs, that you advocate for what they need, and I always believe that if you're advocating for what's right for the patients, because we're in the health care profession, then that's going to be what's right for all to include the staff… I'm administration and I'm also a staff advocate and so, and how you balance those different directives, and what you want is both to walk away feeling like you support both.

Follow-through and Follow-up

Nursing leaders voiced the challenge of balancing staff needs, patient care and safety needs, and fiscal feasibility. An important aspect of advocating for staff as voiced by the nursing leaders pertains to follow-through and follow-up when staff bring a concern to them. Nursing Leader #18 offered this scenario:

> You have to listen to them, gosh, you've got to be able to listen to your staff. I mean, really listen, not just let them blow off steam, you've got to listen to what they say, and act upon it. It's important that you follow

> through. Follow throughs. Otherwise, they'll think it's a waste of time talking to you.

The nursing leaders talked about the benefits of following up and following through in order to gain the confidence of the staff. They avoid making promises that cannot be met. Nursing Leader #9 stated, "I think now that the staff realizes that I don't make promises and that I tell them what my plans are, and hopefully, the plans will come through, and I do 100% to make them come through." The leaders voiced high levels of commitment to accomplish what they promise the staff. When asked which behavior was most important, Nursing Leader #10 responded, "Follow through, absolutely, commitment to the unit, commitment to them and to the care of our patients, and trying to treat everybody equally."

Fiscal: Productivity and Staffing Ratios

Overwhelmingly, the nursing leaders felt having adequate staffing and improved staffing ratios would influence retention. Several nursing leaders felt the current staffing ratios no longer reflect the acuity of the patients cared for on their unit. The employee engagement survey results reflect the staff's perception that they do not have enough resources, staff, to meet the workload. The nursing leaders felt that improving staffing ratios would not only improve the quality of patient care, but staff satisfaction as well. As one nursing leader indicated, "If I could lower nurse-patient ratios, I think it would have the biggest impact. The nurses are very frustrated when they cannot devote that time to someone that is really ill. I think if they had a less nurse/patient ratio that they would feel like they're accomplishing the best care for their patient" (NL#9). In support of this position, another nursing leader stated, "If you ask any of them, I'm sure they would say

staffing, that came across loud and clear in the survey too. We do not have enough to do our job" (NL#18).

To validate the data collected during interviews, the researcher asked the focus group, "Do you think if you carry out the things listed under the Administrative and Professional Domains that it would have any impact on your employees?" Responses included, "Definitely." "I think they [staff] do need, as professionals, to have a better understanding of the fiscal component of what's going on." The focus group participants felt this understanding extends from the nursing leaders to the staff. Their job ties into productivity, which in turn ties into the organization and keeping it fiscally solvent.

Summary and nursing leaders' suggestions.

During the interviews, the nursing leaders talked extensively about behaviors and attitudes that they believe influence staff retention. The researcher used axial coding to develop two subcategories of the Behaviors and Attitudes theme. These subcategories, Administrative and Professional, delineate the behaviors and attitudes the nursing leaders mentioned frequently and felt made the most impact on staff retention. The nursing leaders offered numerous suggestions for staff retention. Table 8 summarizes these suggestions. In addition to nursing leader behaviors and attitudes, the nursing leaders discussed additional factors influencing staff retention and turnover. The following sections, Employee Factors and Turnover, address these themes.

Employee Factors

Although the nursing leaders mentioned numerous behaviors and attitudes they perceive influence staff retention, they also discussed many factors that pertain to the

employees themselves that influence turnover or intent to stay. Based on the interview data, four factors relating to employees surfaced. These factors include job satisfaction family/life circumstances, educational development, and career development. The researcher derived these concepts from Codes 3-5 and 15 in response to the following interview questions:

3. You recently received the results of your unit's employee satisfaction scores.
    a. Were there any surprises? Please elaborate, **or**, If so, how did the results surprise you?
    b. What factors do you believe influenced these results?
        i. Which of these factors do you feel are within your control?
        ii. What do you plan to do to maintain or alter these factors?
        iii. For those factors you feel are outside your control, how do you plan to address these issues with the staff?
    c. Are you satisfied with the results?
    d. What do you feel might change or influence future results?

4. What is your unit turnover rate?
    a. Have you seen a change in your turnover rate in the last 12 months [or since you assumed this position]?
    b. What do you feel accounts for this level of turnover?
    c. How do you think you, as the director of this unit, influence turnover?

Table 8. Nursing Leaders' Suggestions for Staff Retention

Caring/Interpersonal Relationships
Write notes
Send Birthday card
Demonstrate caring
Calm the staff
Get to know your people
Schedule individual interviews with staff; Meet 1:1 to get to know staff
Ask administration to come and talk with staff
Staff Development
Assess needs
Assess staff orientation to floor. Make it appropriate to level of care for the patient population
Match orientee with preceptor; can change if not working out
Utilize new graduate program
Encourage staff development
Encourage staff participation in hospital events and unit events
Communication
Follow-through
Hone listening skills
Become organized
Begin a peer recognition program
Recognize achievements
Round on staff
Hiring the Right People
Develop a relationship with Human Resources
Communicate with HR regarding unit needs
Hone interviewing skills
Involve staff in the interview process
Miscellaneous
Ask staff to commit to a year with a new director
Bonus for retention vs. recruitment
Tips from nursing management magazines

Job satisfaction.

The annual Employee Engagement Survey provides nursing leaders with data regarding staff satisfaction on their unit. Table 9 provides a summary of data provided by the nursing leaders on the Employee Engagement Survey.

Table 9. Nursing Leader Perception of Employee Engagement Survey

Level of Satisfaction with Results	
Satisfied	8
Dissatisfied	5
Surprised by Results	2
Felt results were Improved or Improving	3

The nursing leaders indicating dissatisfaction in the scores offered a number of reasons for feeling this way. In two of the units, staff dissatisfaction stemmed from the Clinical Coordinator working in the unit at the time of the survey. In one unit, the Clinical Coordinator was not a "people person" and she would start "yelling at them about their behaviors instead of figuring out all right what's going on here and this isn't acceptable" (NL #6). The nursing leader attempted to work with this clinical coordinator; however, ultimately, she removed this person from the position. A similar situation occurred in another unit, that clinical coordinator was terminated when counseling, and coaching failed to improve the situation.

Senior Administration

Many of the nursing leaders' dissatisfaction came from the result in which the staff, through the survey, voiced dissatisfaction with the level of visibility and

communication from senior leadership or administration. The focus group validated this concept. The researcher posed the question to the focus group, “The interview data suggest that the staff are dissatisfied with senior administration. To what extent do you feel this dissatisfaction has led to staff leaving [study site]?” None of the focus group participants felt that staff left the facility because of dissatisfaction with senior leadership despite it rising as a top “problem” on the employee engagement survey. One nursing leader felt that the lack of visibility of the senior leadership team contributed to the perception of the staff that the senior leadership team failed to communicate with them adequately. In the interviews, several of the nursing leaders felt they had not done a sufficient job in relaying communication down from senior administrators. One nursing leader stated, “The [negative] comments were mainly senior leadership directed. And that did not make me happy because senior leadership is my leadership” (NL #8). With regard to visibility of senior leadership, one nursing leader stated, “[The staff] don’t feel they know senior management, or they're not visible and when talking to the staff, they don’t even know who our CNO [Chief Nursing Officer] was or our Assistant CNO; they said they wouldn't know their CNO if she walked down the hall” (NL #3). She has since invited both to attend her staff meetings. With regard to communication, another voiced,

> [The staff] felt like communication wasn’t coming down, and I feel like now, I guess, I have a better understanding of how things should trickle down. And maybe I wasn’t communicating well enough to, I guess, to give them the feeling that senior leadership was communicating to them, so they felt senior leadership was not communicating (NL #7).

Tangent to downward communication was the perception of the employees that senior leaders did not follow through with “[doing] what they said they would do.”

Several nursing leaders related how senior administrators came through the unit and the staff verbalized a need and then thought the administrator would immediately act upon it. The staff then became frustrated when the follow-through did not occur. In a couple of situations, the nursing leaders described how their unit was promised a "facelift," but because of budget constraints, it did not occur. Again, staff perceived these situations as administration not following through on what they said they would do. Unless the staff's perception of senior leaders changes, several of the nursing leaders remarked they do not anticipate the 2009 employee engagement survey results to be much different from the 2008 results.

Staffing Ratios

In addition to communication and follow-through from senior leadership surfacing as an area for improvement, the nursing leaders report that the staff voiced displeasure with not having the resources needed to adequately perform their jobs. Specifically, the employees wanted more staff (improved staffing ratios) and dependable technology. Nursing Leader #4 indicated, "Our biggest challenge for improvement was for staffing levels and workload." Many of the nursing leaders felt that improving staffing ratios is outside of their control. Administration determines productivity targets. What they felt was within their control related to staffing pertains to hiring the right staffing mix. In talking about this concept, one nursing leader said,

> They did request more staff, but what they wanted was more skilled staff, so not necessarily more nurses with inexperience. They wanted to be able to balance the experienced with the inexperienced. But that is somewhat within my control because it goes back to, if I do get a candidate, I need to follow through with it (NL# 10).

Benefits and Compensation

Another factor nursing leaders perceive as outside of their control that emerged from the employee survey as an element of staff dissatisfaction is benefits and compensation. To help the staff understand benefits and compensation, many of the nursing leaders requested Human Resources come to their staff meeting to talk with the employees. Similarly, they invited senior leaders to attend these meetings as well in address the communication and visibility concerns of the employees.

Factors Nursing Leaders can Control

Despite identifying the above mentioned elements as outside their control, the nursing leaders felt that there were things that they could do within their control to influence future employee engagement surveys. These factors include advocating for resources (staff and equipment), being visible on the unit, balancing the shifts with experienced and inexperienced staff, improving communication from senior leaders to the staff, hiring the right people, and focusing on staff retention. All those who indicated dissatisfaction with the survey results reported having an action plan that they had already implemented or were currently in the process of implementing.

Nursing Leaders' Perceptions of Employee Engagement Survey Results

As Table 9 shows, eight of the nursing leaders explicitly voiced satisfaction with the results of the employee engagement survey. They offered many reasons for staff satisfaction with the unit and facility. These reasons include a flexible schedule, teamwork, employee engagement in unit activities, employees feeling valued, staff

feeling the unit has a positive work environment, and the staff are generally happy with the unit/hospital.

Reasons for Staff Satisfaction

A nursing leader of a unit with very low turnover stated, “Everybody, work-wise, seems to me, pretty happy on that unit. They're happy with their Clinical Coordinator. They seem to work very well together. Doctors get along really well with them, so, and there aren’t any openings” (NL #6). For another nursing leader, creating this environment arose as an early challenge for her when she first assumed the nursing leadership position. She described the transformation on her unit this way:

> I see teamwork a lot better than before. Teamwork was almost nonexistent. Everybody had their clique and their friend, and they did this, and everybody [else] was left hanging. Now, I see the staff going around and if they're not busy, asking others if they need help. If a nurse’s call light is ringing and they know she’s in an isolation room, they go in that room for her instead of waiting for her to come out of her isolation room (NL #9).

The nursing leaders spoke positively about their staff. Nursing Leader #14 stated, “I have good staff, I think they're here to do a good job.” In discussing their units and staff, the most frequent descriptors to emerge related to teamwork and the staff “working well together.” Those who described their staff as “happy” attributed this satisfaction to the staff working well together and liking their co-workers and unit leadership team. The nursing leaders emphasized the importance of hiring the right people for the current team. One leader indicated, “We're bringing in people and making it feel like a team. They know that everybody is in there working together and everybody is working just as hard” (NL #7). Building the team means creating the right balance of experience and positive attitude. In building her team, a nursing leader reported a new graduate nurse saying to

her, "'Please give me the chance to prove myself in an ICU. I really want this experience and I'm willing to do this, this, and this for you to give me a chance.'" This nursing leader went on to say,

> I've really been lucky and hired some really good nurses because I've seen, you can have experience but not have that drive and a positive attitude. Because we can teach them how to do the Swans, but you can't teach somebody teamwork and a positive attitude. We've got a little bit of inexperience, but I think it's coming along (NL #15).

Another nursing leader described her unit as having the right balance of "seasoned" nurses and new nurses.

Building the right team positively influences the reputation of the unit. The increase in teamwork and improved staffing levels has helped one nursing leader's unit to improve the unit's reputation. Several nursing leaders gave examples of how, since they assumed leadership responsibilities of the unit, and hired the "right" people, the reputation of the unit has improved. When she first arrived, this nursing leader described the unit's reputation as

> … at the bottom, so it was kind of like working from the bottom and coming up, but I think it has definitely changed. I think it has a long way to go. But, I think it's definitely getting better…we've been able to bring in some people that, we're bringing in people and making it feel like a team. They know that everybody is in there working together and everybody is working just as hard (NL #7).

Another nursing leader who faced a challenge when taking the nursing leader position indicated, "It's no longer a pit. I do have a lot of applicants, and the people that are here, I would say for the most part like it here" (NL #18).

Limitations of Employee Engagement Survey

A couple of the nursing leaders voiced concerns about the limitations of the Employee Engagement Survey. One leader indicated, “I don't think the Gallup survey always captures what people’s true perception is about their unit or how they feel. It’s very vague, and I feel like the answers can be interpreted in numerous ways.” A nursing leader in the focus group made a similar comment regarding the survey. She expressed dissatisfaction with doing these surveys. She commented, “I dread that survey. I think it is a vehicle for negativity. I do not see anything positive about that survey.” The survey does not always reflect what the nursing leaders actually see. One of the nursing leaders who indicated surprise in the results responded in saying,

> Yes, there was a surprise. The surprise was that 96% of the [unit] staff indicated that this was a good facility to work at. However, in talking to staff day-to-day, they don’t necessarily reflect that. They reflect that this is not a good place to work and it’s not necessarily because of management; it's because of their colleagues and how their colleagues treat each other.

Nurse-to-nurse hostility surfaced as an issue in a couple of the units. The nursing leaders plan to take a multi-method approach to address the issue of horizontal hostility. One nursing leader stated,

> We also had some horizontal hostility going on. I've been in talks with [Organizational Development] for several months, and we're actually finally doing mandatory classes in that unit starting tonight…a lot of intimidation by the more senior nurses…there was a lot of nasty grams being left to each other, just behaviors that just shouldn't be going on. …We're calling it Nurse-to-Nurse strengthening relationships, but we're really trying to nip that bullying and telling everybody that it’s not acceptable (NL #6).

In these situations, the nursing leaders acknowledge their challenge in holding the staff accountable for professional behaviors and have clearly

communicated what the expectations are and the staff's responsibility in making the unit a better place to work. In one unit, the nursing leader's action plan included active involvement of the staff.

> We obviously reviewed the employee engagement survey with the staff. We did come up with ways that they can work more together, that the explanation was that this really their survey and they are talking about themselves when they talk about 'My work group works together to get things done,' or 'My work group works well as a team"…Consequently they have to develop more interpersonal relationships with each other or better interpersonal relationships. And, to take part of that, they have to be able to communicate with each other. They have to talk to each other. The management can't always handle their situations, I mean, sometimes it's just merely talking colleague to colleague. Peer pressure goes a lot farther than [when] management keeps yapping about the same things (NL #11).

Many nursing leaders acknowledge the difficulty of the work and work environment. When queried as to what keeps the staff coming back, a nursing leader responded, "You know, that's a good question, because you hear people say, 'I'm so frustrated with this place, I don't want to work here anymore,' but they're still here, or they still come back…They come back every day. I'm thankful for that" (NL #19). According to the nursing leaders, this attitude of gratitude, when communicated to the staff, makes a difference in the level of staff satisfaction and ultimately, in retention of staff.

This section explored the nursing leaders' perception of employee job satisfaction. The nursing leaders identified other employee factors influencing staff turnover or retention. The next section addresses the remaining three employee factors.

Family/life circumstances, educational development, career development.

The other employee factors that emerged from the data include family/life circumstances, educational development, and career development. Family/life circumstances include situations in which the nurse assumes care-giving responsibilities for a family member due to illness, aging, or birth. Also described were situations in which a significant other had a change in job and necessitated the family moving. Educational development describes situations in which the employee pursues continuing education to continue in the same nursing role or to move to a different specialty care position. Career development describes a situation in which the nurse seeks a higher degree in order to move to an advanced level of nursing practice, such as obtaining a Masters degree in order to move into a leadership position or to function as a Nurse Practitioner. Career development also included situations in which a staff member was promoted to a leadership position. These three concepts or employee factors have the potential to influence staff retention or turnover. Since the nursing leaders talked about them most often within the context of turnover, data supporting these concepts will be presented in the next section on staff turnover.

Turnover

Nursing leaders' perceptions of turnover rates.

Turnover emerged from the data as a third theme. As defined in Chapter 1, turnover denotes situations in which an employee's employment ends, either on a specific unit or with the organization, and either voluntary or involuntary. The interview questions related to this theme included:

3. What is your unit turnover rate?
    a. Have you seen a change in your turnover rate in the last 12 months [or since you assumed this position]?
    b. What do you feel accounts for this level of turnover?
    c. How do you think you, as the director of this unit, influence turnover?

Codes 6-8 contain data obtained from the nursing leader responses to these questions. The nursing leaders were asked about their turnover rate on the demographic sheet as well as during the interview. Most of the nursing leaders did not know the numeric turnover rate for their unit and gave responses such as "low," "high," or "average." For this reason, the researcher contacted the study site's Human Resource Department and obtained the information related to turnover. The data obtained referenced turnover rates for a 13-month period between October 2007 and October 2008. The average turnover for the nursing leaders participating in the study was 15.78% with a range of zero to 41.7%. This rate compares to all nursing units at the study site with an average of 14.69% and a range of 0-41.7. Table 10 depicts how the nursing leaders perceived their turnover rates and the average turnover rate for the units falling into these levels based on nursing leader perception.

Table 10. Nursing Leaders' Perception of Turnover, n=19

Level	n	Average turnover (%)
Low	11	12.58
Average	2	18.58
High	6	17.92

Table 11 shows turnover based on specialty area for areas represented by the study participants.

Table 11. RN Turnover Based on Specialty Area

	n	Mean (SD)	Minimum	Maximum
Medical-Surgical	7	15.94 (8.02)	0	22.7
Critical Care	10	15.38 (7.35)	3.3	24.2
Womens' Health	7	12.66 (6.91)	7.2	23.4
Other: Pediatrics, Surgical Services, Emergency Dept.	8	18.18 (13.35)	3.6	41.7

Note. The n represents the number of units included in the calculation and not the number of nursing leaders. Many nursing leaders oversee multiple units with distinct turnover rates.

When asked about turnover, two nursing leaders indicated, "People want to come here." One indicated that she had a waiting list of applicants. Another nursing leader with oversight of multiple units with low turnover rates described the units as having "a very, very strong reputation and nurses want to come to our area. So, we really do not have a problem with retention or recruitment. As a matter of fact, sometimes I can't take people that want to come here because we don't have those opportunities." Those with low turnover rates identified several reasons for staff staying. One leader stated, "I think they stay because they like the unit, they like their co-workers, they do feel like it's a good place to work, and they know that the grass isn't really greener somewhere else" (NL #14). Another nursing leader indicated, "[My unit] is kind of a niche area, and I think once nurses find their niche, they stay." In addition to these reasons, a couple of nursing leaders described the strength of the unit leadership team as a reason why staff stay.

Reasons staff leave.

In response to why staff leave, the nursing leaders gave a multitude of reasons for staff leaving the unit. Table 12 lists the top reasons nursing leaders offered and the number of nursing leaders giving this as a reason.

Table 12. Reasons Nursing Leaders Gave for Staff Leaving their Unit, n=19

Reason	Frequency mentioned by nursing leaders
Growth Opportunities	13
Moved	13
Positive Turnover	9
Compensation	8
Competition	7

Note: The frequency numbers do not add up to 19 because the nursing leaders gave multiple reasons for why they believe staff leave the unit.

Growth Opportunities

As mentioned in the previous section on Employee Factors, staff leave a position to explore opportunities for educational growth. These opportunities include moving to a different specialty, a higher level of care or position, or a change in career. The nursing leaders viewed this type of turnover favorably. In most cases, these nurses stayed within the facility. Nursing Leader #12 stated, “Three of them, went to [the other campus] in management positions. And, I couldn't offer that here. I didn't have any openings for those [nurses in management].”

Nursing leader #13 recounted this story regarding a nurse leaving her unit to pursue a position in a specialty area, yet continued to recruit nurses to apply to the unit she was leaving:

> We had a nurse that went to another unit and even in her last days, as she was preceptor, the students that were coming here, she was saying, 'This is a really good floor for you to be on', and she told them, I mean, a couple of the nurses said they wanted to come here and they wanted to come here because she was such a caring preceptor and she told them, 'I'm not staying', and got this look, 'but it was I'm not leaving the floor because of anything else except that they have an opening where I want to be and I'm ready to go.' And I ended up getting two of those nurses because she was such a good preceptor and because she took advantage of the opportunities here on this floor (NL #13).

The Medical-Surgical and the intermediate care nursing leaders frequently described their units as "training grounds" for other units. One nursing leader indicated, "There's a lot of fluidity. They are looking, some are looking to see if there's ICU positions" (NL #5). This nursing leader had two nurses leave recently. She stated, "One went to [the other campus], to the PACU, and the other went to a labor and delivery unit [at a different hospital], which is what she's always planned to do." Faced with a similar situation, another nursing leader stated,

> Most of the staff that left were newer nurses that were using Med-Surg as a stepping stone, which is a good thing. You learn a lot on a Med-Surg unit, so they wanted to get into more critical care (NL #9).

In response to the question, "Have you had anyone leave since you came?" Nursing Leader #10 responded, "Yes, to pursue other opportunities. Education-wise, one went to nurse anesthetist school. One that I hired as a new graduate moved back home."

Family/life circumstances.

The nursing leaders identified "moving" as the second most likely reason for nurses to leave a position. Nursing leader #4 lost nine nurses for this reason in the last year. She stated, "Nine of them moved out of the state. So one of them, two of them moved greater than two hours away from the hospital, but still within the state." Nursing Leader #11 offered numerous reasons for the staff leaving.

> Some people have left to go to other opportunities outside of Virginia. Some people have left for clinical or career advancement, but the majority of people left because they didn't like the fact that we were holding the people accountable.

<u>"Positive" Turnover</u>

Nine nursing leaders described situations in which they encouraged or facilitated turnover. They viewed these situations as "positive turnover," the third most common reason the nursing leaders offered for why staff leave. Nursing leader #13 bluntly stated, "Some of the turnover has been because of me." She went on to say,

> My first year here, you're having to get to know who your people are, what their strengths are, what their weaknesses are, setting your expectations, holding them accountable, things like that, seeing which ones are willing to, because the bar was being moved up, who wanted to come up to this bar, and who were willing to come up to this bar…We've gotten to the point now where, okay, I'm not tolerating that. Some people, I've had to make examples out of people because of that and so that's where we are now. Either come and go with us where we're going or you need to either find another unit or find another home, because this is not your home any more. So, that's where we are now, so some of the turnover is because of me.

Nursing Leader #9 faced a similar situation when she first came into her position. She stated, "The turnover, it was something that really had to be done" because the unit did not run effectively and had a poor reputation. She went on to say, "The older nurses

that had been here forever had seen this come about. They were very dissatisfied, and they put a lot of years into it. So, it all had to be redirected and the ones that wanted to turn it around did, and the ones that didn't want to went elsewhere." By facilitating turnover, this nursing leader created a staffing shortage on her unit. She admitted,

> Staffing was tough there for a while, but I came in and worked nights. I came in and worked weekends, and I think the staff saw that I was not going to leave them hanging, that I would be out there, not just standing at the desk being in charge, but that I'd have a patient assignment and be caring for patients with them. So, I think that helped a lot.

Along a similar vein, in response to two nurses being terminated for poor performance, Nursing Leader #10 stated, "It was positive because the performance issues were impacting the rest of the team."

The nursing leaders spoke frequently to holding staff accountable for professional and clinical behaviors. A nursing leader described the importance of following through with holding staff accountable stating,

> If you're saying that the people that are not accountable will not be here and you truly are getting rid of them, [the staff are] going to be watching for that as well. They're going to be more satisfied if you're actually doing those things because you're going to be left with the people that want to do the right thing, that are committed to and value the things that you value on your unit, and so you're going to have a better team, that right match for your area (NL #16).

Terminating these employees can also prompt those who left the facility to return, as was the case of one unit. Nursing Leader #3 described this situation.

> I've gotten some people out, like the bad turnover and the good turnover, some of it's been good turnover; I'm hoping it will stabilize out now…probably five nurses have come back since I've been here because those people have left. Because of their attitude…just since I've been here,

> I've had people leave because of attitude, but they've been part of the problem.

In addition to terminating poor performers or those not meeting the unit's standard, the nursing leaders described situations in which they did not try to retain staff who did not fit well with the unit. Nursing Leader #14 described this situation.

> There have been people that have left that I didn't try to retain them. I can tell you that, because I did feel that they weren't a good influence on the unit, either clinically or just in the personality mix of the unit. My approach really is to use opportunities with people at least initially as an educational opportunity and give them a chance to recognize or own either their mistake or their behavior or their attitude and change it. And if that doesn't happen, then I go down the corrective counseling path.

Nursing Leader #19 agreed that staff who are not the right fit are better off transferring to another unit in saying, "It's a very hard place to work, and it takes the right people and the right fit. It's okay if they're not the right person, right fit, to go." Other nursing leaders echoed this sentiment. When faced with this situation, most nursing leaders tried to help the individual assess his/her strengths and then facilitated a transfer within the facility to a unit that might be a better fit for the person. Again, the nursing leaders viewed this turnover as positive and a win-win situation for the individual and the hospital. Internal transfers, although still turnover, incur less orientation costs than hiring outside individuals.

Competition and Compensation

The last two common reasons nursing leaders gave for staff turnover pertained to factors the nursing leaders believed to be outside their control— competition and compensation. These two factors will be addressed simultaneously due to their

interrelated nature. As Nursing Leader #2 indicated, “This is a competitive market and some of them are going for the highest buyer, highest bidder.” One nursing leader indicated that she had four nurses leave in the last year to go to a different facility because they were offered a higher hourly wage. In their exit interviews, these nurses “were very complimentary of working here, very complimentary of [the nursing leader] which made [her] feel that it wasn’t management. It wasn’t the staff here. A lot of it was money” (NL #14). She elaborated by saying,

> I do think that they're lured by promises of money. Whatever schedule they want to work, they're going to be given, and maybe they think there aren’t going to be as many rules or policies or whatever to follow.

Suggestions for when Staff Voice Intent to Leave

In addition to these insights into staff turnover, the nursing leaders discussed how they address staff voicing intent to leave. One suggestion included conducting an exit interview with the employee to learn what prompted his/her decision and what the leader or facility could have done differently or better. When faced with staff contemplating leaving, one nursing leader suggests, “Talk to the staff. Find out what they felt were the short-term goals and the long-term goals for the unit. And then find out what the, what was causing them to make choices that might pull them away from the unit” (NL #5).

The nursing leaders also described situations in which negative behaviors of the nursing leader prompts staff to leave. Many of these situations illustrated behaviors in which the leader demonstrated poor interpersonal skills or failed to demonstrate caring. Nursing Leader #10 described it this way,

> I wouldn't want to work for someone who I felt didn't really care about me as a person, as an employee, who didn't care about the care I gave to my patients, or maybe if I brought a problem to them and they just went, 'Oh yeah, whatever,' or I felt like I wasn't being heard, or issues weren't addressed, equipment issues weren't addressed, performance issues that directly impacted patients weren't addressed. I think I wouldn't want to work for that person.

Several leaders offered personal situations in which they left a staff position because of the nursing leader. Nursing Leader #15 said,

> I had one that I had a situation and she asked me exactly what happened and then at the end of the conversation she just said she didn't believe me. And, I left because I couldn't work for somebody that didn't think that I was honest and trustworthy. And that's the first time I've ever had that before. And she was very unapproachable and that's just not the kind of person that I want to be.

Nursing Leader #14 described her situation this way,

> I think people don't want to work for bad directors. I've had a bad director before and I didn't want to work for her. Not here and I did leave that job because of my director. I think that a director can definitely influence the turnover if you're unfair or inequitable, or don't treat people well, or you're not supportive of them in their role as a nurse.

All the nursing leaders felt they influenced staff retention or turnover in some way. As Nursing Leader #19 said, "Leadership is a huge factor in making people want to be there and want to stay." In some situations, a change in leadership prompted staff to reconsider leaving the facility. Nursing Leader #2 indicated, "A lot of them just verbally told me that they stayed because of me." In a unit with frequent leadership turnover, when told that she would not be there in a year, the nursing leader told the staff, "You stay with me for that year, and I bet you I'll be here for that year." She demonstrated commitment to the staff and in return, they committed to stay with her.

The data from this theme illustrates the nursing leaders' perception of why staff leave positions. The nursing leaders strongly felt that not all turnover is bad; there are situations in which creating turnover improves the work environment. Nursing Leader #5 stated,

> If there is no turnover, that's not always a good thing, either, because then you have such a tight clique of people that work very well together but may not work well if other people come into the unit.

Summary

The data offered in this section aided in answering the research question on what behaviors and attitudes the nursing leaders perceive influence staff retention. The main themes emerging from this data relate to nursing leader behaviors and attitudes, employee factors, and turnover. The behavior and attitudes category encompassed two subcategories, administrative domain and professional domain. The professional domain described behavior and attitudes related to interpersonal relationships. The administrative domain described behaviors influencing the day-to-day operation of the unit as well as human resource management behaviors. The employee factors theme offered data on employee situations and characteristics that influence whether an employee will stay or leave a position. Lastly, the turnover theme described the top five reasons nursing leaders gave for staff leaving a position, either voluntary or involuntary. The interrelationship of these themes and how these themes relate to the literature will be discussed in Chapter Five. The next section of Chapter Four provides the reader with data on the second research question this study sought to answer.

Research Question 2

Introduction

Given the pivotal role nursing leaders play in staff retention and their influence in turnover, the study sought to learn, "To what extent do nursing leaders feel current leadership education and training programs support their practices that promote staff retention?" To learn the nursing leaders' perspectives on this subject, the researcher asked the following questions during the interviews:

5. Tell me about your training to prepare you for this position.
    a. What training/education have you received that has helped with regard to retaining staff?
    b. What do you think would help you learn or implement strategies for retaining staff?

6. What was your level of comfort in terms of your leadership/management skills and abilities related to staff retention when you transitioned into your current position?
    a. Tell me about your orientation to this position. How was staff retention or turnover addressed?
    b. What additional education or training would you have found beneficial?

7. If you were designing an educational training program for new nursing leaders, what elements related to staff retention would be important to include?
    a. Which ones do you feel are critical to staff retention?
    b. Please rank these elements in order of importance. Describe why you ranked them the way you did.
8. What level of education do you feel is necessary to be effective as a unit director? Why?

Data from these questions were coded in Codes 10-14, 19, and 20, yielding 342 data units (30%). The data for Question 2 will be presented in four sections: Preparation for nursing leader position; factors influencing level of comfort with the nursing leader position; level of education recommended, and suggestions for training new nursing leaders.

Preparation for the Nursing Leader Position

Table 13 lists the top five ways nursing leaders said they prepared for their position.

Table 13. Preparation for the Nursing Leader Position

Classes as part of degree program: Bachelor of Science in Nursing, or Masters level program
Classes through Organizational Development
On-the-job training; Trial and error
Mentors
"No orientation" or "Not much orientation"

In response to the question on preparation for the role, Nursing Leader #1 responded, "Most all of my training has been on the job, learn as you go. I have had some very good mentors and administrators in other facilities and here too." Nursing Leader #4 echoed with the statements, "Trial and error, on the job training. I was a staff nurse when I first came out of nursing school, transferred here, was flexi and had no real training for management."

Many of the nursing leaders recounted having worked briefly as a shift manager (clinical coordinator or charge nurse) prior to moving into the nursing director or leader position. The swiftness with which they were promoted resulted in little or no orientation time with the previous nursing leader. Nursing Leader #8 stated, "I was Clinical Coordinator here for a month before [the nursing director] left." Another nursing leader

experienced a similar situation. She recounted, “I was hired up here as the assistant director. The day that I came up here, the director resigned. So, my orientation that I was supposed to have was cut very, very short. So I did a lot of on-the-job training” (NL #13). Four nursing leaders explicitly indicated that staff retention was never mentioned as part of their orientation. One nursing leader mentioned that when she was hired, she was told about her open positions, but not instructed or offered recommendations for strategies for retaining the current staff.

One of the experienced nursing leaders commented on her perceptions of the orientation process currently in place. She stated, “People have a tendency to just get thrown into their role… I don't think it’s a very good, organized director orientation” (NL #12). She related having worked on a nursing orientation plan with other nursing directors several years ago, but does not know why it did not come to fruition. Having come to the facility in the previous 12 months, Nursing Leader #5 offered these comments on the nursing leader orientation process, “It’s kind of a self-orientation… nursing director’s orientation really is an area of opportunity… making sure that when the new person comes in that they’re assigned to another, to a mentor would be a big help.”

Twelve of the 19 study participants described the importance of mentors or modeling after previous leaders in preparing them for their role as a frontline nursing leader. In discussing mentoring situations, the nursing leaders offered the following descriptions:

- But I feel that with her leadership, I was able to see ways that we can actually work toward retention as far as peer recognition program (NL #5).

- I guess more important of the formal things was the mentors I had along the way, even as a Charge Nurse or Unit Clinician…I watched how they managed, and I watched how they led, and I watched how they dealt with issues and problems and how they reacted to things and I would learn (NL #8).
- I've been very lucky, I think, to have some really good mentors and some nice people for bosses who have helped me, not only professionally but personally. So, I think that's what's kept me here (NL #12).

Many discussed learning what to do or not do by watching previous leaders. Nursing leaders offered positive and negative comments related to previous role models. Positive comments regarding behaviors and attitudes they desired to emulate included:

- So I probably learned more from my preceptor than I did anything or anybody else. And I had a very good preceptor…I just role modeled after her (NL #12).
- She was just always approachable and always was there for you and if you needed anything, she was there. She knew the [unit]. She just had the whole package and that's what I want to be, that's the kind of director I want to be (NL #15).

Nursing leaders also described situations in which they did not want to emulate previous nursing leaders. Nursing leaders described these situations as:

- The previous director…was very micromanagement. Like she had her hands in everything. And you could not do anything without her. And I'm not like that at all (NL #2).
- I've tried to model my behavior over, not just people that I would try to attain to be like, but those that have turned me off in the past, and that's been directors that I've had in the past that have been negative or more doom and gloom (NL #6).
- I actually was out of management for a couple of years, went back to bedside, enjoyed that immensely, and I think it gave me another healthy perspective on what, on how important it is to be a good leader, because I worked for people that did not exhibit some of these characteristics and attitudes. And I realized what a dissatisfier that was for me as an employee (NL #10).
- She was very unapproachable and that's just not the kind of person that I want to be. I think that turns, that immediately turns the staff off and if I'm just going to be a desk person, somebody who sits behind a desk all day and pushes a pencil and doesn't understand what the bedside nurse is going through every day, then you don't get the respect that they need or deserve (NL #15).
- In discussing the previous nursing leader for the unit, the current nursing leader made the comment, [The unit] did not have nearly enough staff. They did need

Previous role models and mentors helped shaped the nursing leaders and influenced them in the type of leader they desired to become. In addition to mentors and role models, most of the nursing leaders acknowledged taking leadership courses, either through the facility's Organizational Development department or as part of a degree program. Most of the training mentioned by the nursing leaders occurred outside of an academic setting.

The director of the Organizational Development (OD) department at the study site provided the researcher with data on the classes offered at the facility. Appendix I contains a listing of the classes offered for 2007 and 2008. The researcher collected data on class attendance for 2007 and 2008. Classes attended in the recent past tend to have the most influence on current behaviors. During the designated time, OD conducted 44 sessions of 23 different classes. The classes most frequently attended by the study participants were labor relations, Gallop training, and generational diversity. Eight of the participants attended a class on recognizing employees. Only one nursing leader in the study attended the class on Retention and Recruitment in the last two years. While collecting the data on the study participants, the researcher noted a significant number of shift leaders, clinical coordinators and charge nurses, attending the sessions as well.

The director of OD reported that the corporate office designated four leadership classes as mandatory for the nursing leaders to attend over the next 12 months. The four

mandatory classes include “Intimidating and Disruptive Behavior,” “Targeted Selection,” “Generational Diversity,” and “Performance Management Plan.” The “Intimidating” class addresses horizontal violence. Several nursing leaders voiced experiencing situations with nurse-to-nurse hostility. “Targeted selection” focuses on hiring practices. The researcher did not see any of the study participants on the sign-in sheet for the Targeted Selection session offered in November 2008. Two nursing leaders attended the December session of “Performance Management Plan.” Fourteen of the 19 study participants attended the “Generational Diversity” session offered in November 2008. All new nursing leaders attend an eight-hour class on “Essentials Skills of Healthcare Leaders.”

Nursing leaders with a Bachelor’s degree or a Master’s degree related how the classes in these programs have helped them as a nursing leader. Nursing Leader #18 offered this insight into the benefits of a Master of Science in Nursing (MSN) degree,

> I came out with a Masters degree and that’s the best thing that ever happened to me, the Masters degree was just invaluable. The Masters, you delve more into how to read people. For me it was a broader vision of what’s going on. All the leadership classes, and the people that taught me were, they were at the top of my list.

Nursing Leader #15 stated, “In the four-year [BSN] program, we had more leadership classes. We had nursing leadership classes, we had just more thinking and not just task oriented that some of the diploma schools have.”

The nursing leaders also felt experience played a key role in preparing them for their nursing leadership position. Experience factored into their level of comfort coming

into the position. The next concept of the Nursing Leadership Training and Development theme addresses nursing leader level of comfort.

Factors Influencing Nursing Leader Level of Comfort with the Position

Six of the nursing leaders voiced feeling uncomfortable with the role when first entering into the position. Two factors surfaced which influence the nursing directors' level of comfort. These factors include previous experience and working on the unit prior to moving into a leadership position. Nurses with previous experience working in the department for which they later became the nursing director voiced feeling comfortable since they knew the staff and what the issues were for the unit. One nursing leader stated,

> I felt pretty comfortable with it because I knew this [unit]. And, I knew the staff. And I knew that they were ready for a change, not necessarily that they wanted it to be me, but I think they were happy about it, but I just felt like I knew them and I knew the department and I kind of knew what their dissatisfiers were then because I had worked in it (NL #8).

The nursing leaders, who previously worked at the study site as clinical coordinators, assistant directors, or interim directors, expressed higher levels of comfort than those with limited experience in leading people. These individuals viewed moving into the nursing leadership role as a natural progression.

One of the nursing leaders who voiced feeling uncomfortable summarized her feelings this way with regard to where she was when she first took the position,

> On a scale from one to ten? Probably a two. Where is it now? Probably about a six or a seven. But, I mean, I still have room to grow, but it wasn't that great. I didn't know what I needed to do. I didn't know, I didn't have a relationship with HR, I didn't have relationships with other directors or input and feedback from them. So, it has grown (NL #13).

In addition to desiring training on staff retention, several of the nursing directors indicated needing training related to handle “those difficult conversations” pertaining to staff counseling and performance feedback. Several nursing leaders expressed feeling uncomfortable in these two areas of their role.

The nursing directors with a Bachelors or Masters degree expressed higher levels of confidence in their position. The next section provides data on nursing leaders’ perceptions on what level of education should be required for their position.

Level of Education Recommended

Table 14 shows the number of the nursing leaders holding the various degrees.

Table 14. Nursing Leaders and Highest Degree Held, n=19

Degree	n	Percent of Total
Diploma	1	5.3
Associate	5	26.3
Bachelors	7	36.8
Masters	6	31.6

Three of the nurses holding Associates Degree in Nursing (ADN) indicated they were working towards a Bachelors degree. One of the nursing leaders with a Bachelors is working on a Masters in Healthcare Administration. Four of the nursing leaders emphasized that experience often proves more beneficial than a degree. In support of experience having a greater influence on leadership success, one nursing leader stated,

> I have met some very, very, very educated dumb people. Just because you can hold a degree doesn't necessarily mean that you've got what it takes to

> be an effective leader. I don't necessarily feel that you have to have a higher level of education to effectively lead a group of individuals. I think a lot of that comes from common sense and on-the-job training (NL #4).

Nursing Leader #15 agreed that education, for some, may not make them a good leader. She indicated, "Some people have, could have a lot of book smarts and not have a lot of, look great on paper, but then don't have interpersonal skills." One nursing leader emphasized finding the right leader for the unit and the staff stating, "If you're not the right person, then all the book learning in the world isn't going to make you a good leader" (NL #1). Finding the right leader includes looking for someone who demonstrates passion for nursing and nursing leadership. This person has to "love what you're doing, you have to love nursing, and you have to truly care for people. And that as long as you have leadership qualities, I don't think that it necessarily means that you have to have the Bachelors degree in nursing or a Masters" (NL #13). Becoming an effective leader "depends on what kind of person you are and leader you are, and clinical experience you have" (NL #14**).**

When queried regarding the desired level of education they felt a nursing leader should have, eleven felt a nursing leader should have a Bachelors and five felt that a Masters degree should be required. The most frequently reason given was that these degrees "broaden perspective." Comments in support of a Bachelors degree were:

- A Bachelors is "preferred because I think you do get a lot of critical thinking skills and stuff in those types of classes that you don't get in an ADN program or a diploma program (NL #5).

- When I look back at my Bachelors in nursing classes, that's the curriculum that looked outside of just being a nurse and looked at leadership things and global issues through the ANA, and the ENA, and research and evidence-based practice and why we do what we do, and we looked at issues that are confined to country, in health care and in general (NL #8).
- "When I first became a manager a Bachelors was not required and then they put that in place and that's what prompted me to pursue my Bachelors and I'm so glad I did. As I said before, I think it gives you a much broader perspective" (NL #12).
- I am definitely not the same person with the AD. I think it broadened my view. It gave me a more global perspective about how everything works (NL #16).

In supporting the Masters level of education, one nursing leader described the experience as "the best thing that ever happened to me, the Masters degree was just invaluable" (NL #18). The experience was invaluable in that "in that degree you learn all that stuff [about budgeting], here's what you should be doing, here's what managers do, here's what budgeting is all about, here's what staffing is all about." The nursing leader went on to say, "[In] the Masters [program], you delve more into how to read people. For me, it was a broader vision of what's going on. All the leadership classes, and the people that taught me were, they were at the top of my list." In addition to these benefits of a Masters degree, a nursing leader felt "there's so many things that I work on that if I had not gone to graduate school I wouldn't even have known how to do. And it just increases your level of confidence in writing and presenting yourself whether it's special projects or proposals to administration for resources that are needed" (NL #6). In voicing support for Masters level classes, a nursing leader currently with a BSN stated,

> "I think there's a lot of master prepared classes, that are good classes. I think they definitely help you in different aspects, with team building, with managing your team as far as financial, look at your FTE's, looking at your productivity. I'm not saying that you have to be Masters prepared to do the job, but I think that those programs give you better guidelines and tools to be effective" (NL #19)

Those nursing leaders with a Masters degree frequently voiced support of and stressed the importance of staff education.

During the focus group discussion of this theme, level of education generated the most discussion. The focus group comprised of one Masters prepared leader, two Bachelors prepared, and one Associates degree prepared nursing leader who is working on her BSN. Discussion ensued on reasons for requiring a BSN or MSN. The general feeling expressed supported the BSN over the MSN. When asked how the MSN helped, the MSN prepared nursing leader, discussed the benefits of her program—"research, implementing new things on the floor, understanding productivity. All of that helps with team building, staff building. I learned so many things in school. PI [Process Improvement]. I learned a lot about that." While the remaining participants agreed that these elements help, they did not feel that the MSN should be mandatory. One voiced that experience and finding the right person for the unit played a role in the success of the nursing leader. When questioned about the most appropriate process for finding the "right" nursing leader, the group then discussed how the current nursing leadership has done a "fairly good job of hiring people" lately. The discussion then turned to nursing leader involvement in hiring other nursing leaders and whether they, the nursing leaders, could really understand what another unit needs in order to pick the right person. One participant stated that she had been hired because she was a "warm, fuzzy person." Another nursing leader interjected that the previous director of that unit was not warm and fuzzy, and administration must have thought the unit needed a different style of leadership. Laughing, another participant stated, "I guess they will replace me with a

warm and fuzzy when I leave!" The group generally felt that the current administration "have made some good selections for the units they have hired into...Some of the new people they have hired in under their administration have done a really good job." Another nursing leader related the change in nursing leaders to staffing on a nursing floor stating, "It's just like a nursing floor. You turnover a few and you bring in new [leaders], and the people that have been here for a while all mentor the new ones."

Outside of formalized education, the nursing leaders offered suggestions in the area of new nursing leader training and development. This information is present in the next section.

Training New Nursing Leaders

The nursing leaders provided 80 data units on training new nursing leaders. In the professional domain, the nursing leaders once again felt that the most important topics new nursing leaders should receive training on pertain to communication and interpersonal relationships. Communication skills need to emphasize listening, dealing with difficult people, and conflict resolution. In discussing interpersonal skills, the study participants felt the curriculum should emphasize "getting to know your staff," "assessing staff needs," coaching skills, and upholding the values of consistency, fairness, and accountability. Nursing Leader #4 stressed the importance of "accessibility and ability to communicate with your staff are two really big factors in retaining people." Nursing Leader #12 offered this example,

> I hear war stories from other staff where managers when they say, I mean, they just convey not caring, they convey, 'well, that's your problem.' I

> don't think that, well, it's not thinking, that just kills retention and you see so many good nurses that leave because of things like that.

In stressing the importance of visibility and communication, Nursing Leader #18 stressed the importance of new nursing leaders

> knowing what's going on on that unit, being out there among them having a, to get a real feel for that unit, to get to know your staff, more than just knowing a face, I think you, from my perspective, the key to any kind of leadership and retention is being out there with them. And you have to identify education opportunities while you're out there because you see what's going on, you know what's going on, they tell you what's going on, and you can see how you can change it.

Also in the professional domain is the recommendation to train new nursing leaders in team building, staff and unit leadership. In building the unit leadership team, Nursing Leader #5 recommends encouraging new leaders to send charge nurses to the leadership classes. Nursing Leader #6 elaborated on building the leadership team saying the new nursing leader needs to learn

> to build your own management team. In order for you to be effective, you have to make sure that the people that are under you and that are working with you every day, learn to support each other in your decisions. Your management team, you all need to be able to mesh, to be able to talk the same language, and know what would be acceptable for each other.

Part of learning to build the right team also pertains to learning Human Resource (HR) skills from the administrative domain. The nursing leaders identified the following HR skills as important elements for a new leader training program: application process, interviewing skills, counseling skills, and setting clear expectations. Learning counseling skills and how to deal with difficult

employees reaps benefits in the long run even though “it’s painful when you’re doing it” (NL #6). Nursing Leader #6 went on to say,

> Learning to deal with those behavior issues and getting it corrected right away helps the whole group because the whole group says, ‘Well, good for you that you did that, because we all come in on time and we all do such and such assignment and she’s always been given whatever for the last five years’… the reward afterward is you might have helped 15 or 20 other people by dealing with that one difficult employee.

Another administrative domain skill the nursing leaders mentioned was reward and recognition. Supporting this recommendation, Nursing Leader #2 indicated that it is important to “make the current ones here always feel that they’ve done their best.” The nursing leaders offered a wide variety of professional and administrative domain skills that they felt new nursing leaders should learn. While not all directly contribute to staff retention, they contribute to the overall effectiveness of the nursing leader. Table 15 contains a list of the most frequently mentioned topics.

In addition to offering topics for a new leader training program, the nursing leaders made suggestions for training strategies and practical tools. One nursing leader commented on the overwhelming number of new abbreviations she heard when first coming into the position. She stated,

> We need a piece of paper that lays out all the initials that everybody uses and what that goes along with…HCAP. What the heck is that? I know what it is, but I have no idea what it stands for (NL #7).

Table 15. Recommended Topics for New Nursing Leader Training

Administrative Domain	Professional Domain
Human Resource Management	Communication: Listening, Conflict Resolution
Application Process Recruiting & Hiring Interviewing Recognition & Reward Performance Feedback (Counseling skills) Retaining Staff	Visibility & Accessibility Team Building: Staff & Leadership Coaching & Mentoring Delegation
Fiscal: Productivity Reports & Staffing	
Computer Training	
Time Management	
Process Improvement Projects; Core Measures	

The nursing leaders recommended these specific strategies: role play, scenarios, mentoring, shadowing administration, classes, reading materials, outside speakers, development of tools and guidelines for new directors, not having new nursing leaders on the unit immediately, and regular meetings for new directors to discuss how they are doing in the role. An experienced, but new director to the study site, suggested, “I also think that probably having maybe just a class where your new leaders, you sit down and talk about [HR issues]. Bring your new leaders in, and maybe everybody who has been hired within six months, where that is addressed” (NL #10).

Several nursing leaders suggested having the new nursing leaders shadow another nursing leader on the mentor’s unit before assuming responsibility for their own unit. When asked what would have helped her, a relatively new nursing leader replied,

> Probably not coming directly to this unit once I became a director. That working with another director off my unit, so that I could see the day-to-day workings of what the other directors did, how they did it, why they did it prior to me coming and taking over my unit. So at least a week or so with another director off the floor. And not being responsible for this floor while I was with them (NL #13).

Another nursing leader also made this same suggestion. Nursing Leader #15 offered this suggestion for new leaders,

> I think that the new director would need to spend time with HR. And I think the biggest thing would be to educate the new director on the staff needs or the unit needs. I think that the biggest thing that you need to figure out is what's making people unhappy and how to go about doing that because I did individual interviews, and I just came up with that because I wanted to at least learn people's names and faces.

In support of outside speakers, the nursing leader stated, "I think it's really helpful when we go outside the hospital and look at or read about or meet people who are doing different things" (NL #8).

In developing classes, OD should consider "classes not be half days necessarily, because we don't as, in this current role, you don't have that kind of time frame. Two hours are probably the max that you would want to do, but you can do it on serial sessions" (NL #10).

Several nursing leaders suggested the development of a "toolbox" containing tips and suggestions for new nursing leaders. These tools include tips on the various topics recommended for training. They want a quick reference document to refer to when the situation arises. It was suggested that when OD or HR develops a leadership class, they put together a *Quick Reference Guide* for the topic being presented. Nursing leaders would be encouraged to put these in a Human Resource notebook for future reference. Of

particular interest is a sheet on telephone and in-person interviewing, giving recognition, counseling staff, and retention. A new nursing leader who offered some of these suggestions indicated that she would like to

> go into a formal class. Basically, almost like kind of train the trainer or if somebody had planted the seed, these are key things, these are the things you should look for, these are things you should focus on to nurture your staff, to keep your staff, to retain your staff, I think if we had a good guideline or a basis, whether it's department wide, hospital wide, you know, director wide, I think that if we had the tools to help us, then we'd be able to manage it better (NL #19).

Although it increases their workload, several of the experienced nursing leaders voiced a willingness to mentor new leaders. One such leader said,

> I would think that although it would be an additional burden upon me, it would still be of value and help to any new person coming in just to have that person that they can come to, to sit down with and throw things out at them because when you come into a new place, you just don't know the structure, you just don't know how people handle things, you don't know how HR looks at things, but someone who's been here for a length of time and kind of knows everybody and how things go, I think it would be a big help to somebody. So I'm always open to trying to help someone else be successful (NL #11).

The nursing leaders strongly recommended having the mentor on the same campus as the new leader. Those who had a resource person or mentor on a different campus did not find this process helpful. In addition to having the mentor on the same campus, another nursing leader offered this suggestion,

> When they're looking at a preceptor for a new director, it should be somebody who's in good standing. It should be somebody who runs their unit, has a strong unit, a strong leadership quality that they can help pass on to the director that they're helping (NL #13).

Summary

This section delved into the nursing leaders perceptions of leadership training and development, including the academic and orientation process. The majority of the leaders felt that a Bachelors degree should be the minimum requirement for nursing leaders, although some felt that experience played a crucial role and should not be overlooked in the hiring process. The nursing leaders provided much insight into the training needs of new nursing leaders and offered valuable suggestions for educational and training topics. They generally felt that the current on-boarding process could be improved upon for new leaders coming in to the facility. As such, they offered numerous suggestions for strategies to prepare and orient new leaders.

What also came out in searching for answers to the research questions was the influence of external factors on the nursing leaders and how they perform their role. From this data emerged the final theme, *Organizational Culture and Policies.* While this theme does not directly relate to the research questions, it emerged as an important factor that indirectly influences the answers since it constitutes part of the internal environment in which the nursing leaders operate. The next section explores the data for this theme.

Organizational Culture and Policies

Nursing leaders operate within a larger system of the healthcare organization. The effects of this larger system directly and indirectly influence the decisions and actions of the nursing leaders. As with any system, a change or alteration in one part of the system permeates to other portions of the system. In collecting data to answer the research questions, data also arose that eventually became coded into a category on

Organizational Culture and Policies. Within this broad category lie four subcategories: Productivity, Staffing Ratios; Culture of Accountability; Administrative Support; and Administrative Follow Through and Follow Up. Because of the influence of these factors on other aspects of the study, some of the specific elements have been mentioned or alluded to previously in this chapter. This section of Chapter Four presents the evidence supporting this theme based on the subcategories.

Productivity, Staff Ratios

This first subcategory describes the degree to which administrative control of productivity and staffing ratios influence decisions made by nursing leaders. The nursing leaders frequently mentioned staffing ratios and productivity as a source of staff dissatisfaction. In the focus group, the nursing leaders explained that senior administrators determine the number of full time equivalencies (FTEs) a unit can have. The nursing leader determines how to distribute or use those FTEs. Administration holds the nursing leader accountable to stay at or over 100% productivity. The nursing leaders discussed how they must explain variances in productivity in which they run the unit at less than 100%. They described how they strive to be proactive if they know they will run under one day. The nursing leaders discussed strategies for how they manage their staffing in order to meet productivity standards. If the unit runs less than 100%, the nursing leaders attempt to adjust staffing to attain 100% productivity by the end of the week or the month. Some nursing leaders review it daily in order to more carefully manage it. The nursing leaders in the focus group confirmed their challenge involves balancing the productivity with staffing ratios and acuity. Staff satisfaction ties into these

elements. When staffing ratios and acuity rise above the normal levels and persist there, staff satisfaction decreases.

Staffing ratios will continue to prove a challenge since senior administration determines the number of FTEs a unit can have. Discussion ensued about how staffing ratios no longer reflect the acuity of the patients. One nursing leader commented, "Staffing ratios have nothing to do with acuity. It's all about how many people you can have." Although a staffing shortage and high staffing ratios result in lowered employee satisfaction and increased stress on the unit, the nursing leaders in the focus group and during the interviews did not identify it as a primary factor in staff leaving.

Staffing does, however, factor frequently in the decisions the nursing leaders make regarding how they run their unit, what staffing mix they have, and the overall general morale of the unit. Nursing leaders frequently spoke of maintaining a positive attitude and encouraging the staff on days when the staffing ratios or patient acuity is high.

Culture of Accountability

Just as the nursing leaders create a culture of accountability within their units, senior administration also creates a culture of accountability with the nursing leaders. As mentioned in the previous section, senior administrators hold the nursing leaders accountable for meeting monthly productivity targets. Senior administrators meet monthly with the department leaders to review the fiscal status of the organization. In addition to these meetings, leaders communicate with administrators regarding variances.

On an annual basis, nursing leaders receive feedback on the *Performance Management Plan.* The Performance Management Plan, used for annual performance appraisal, links the nursing leader's performance to the organization's Vision, Mission, Strategies, and Core Values. Part I of this document covers predominantly areas pertaining to the Administrative concept of the *Behaviors & Attitude* theme. Key areas evaluated in Part I include volume (admissions), Operational/Financial Performance (revenue /expenditures), Human Resource—Leadership and Retention, Customer Satisfaction, and Quality/Patient Safety. In the Human Resource area, nursing leaders report on turnover, employee engagement scores, employee satisfaction scores, and vacancy rates. Turnover includes total rates, RN rates, and voluntary versus involuntary rates. The Quality/Patient Safety domain covers composite scores for the Core Measures applicable to the unit. Since Core Measure data are reported publicly, administration expects the nursing leaders to make sure their units meet hospital, corporate, and national benchmarks.

Part II of this document evaluates the nursing leaders on eight "Behavioral Competencies/Key Behaviors." Of these eight competencies, three correlate with the data collected—building organizational talent, empowerment/delegation, and communication with impact. The Building organizational talent encompasses assessing staff developmental needs, creating a learning culture, rewarding staff, and emphasizing retention. Key behaviors to achieve the empowerment/delegation competency include promoting accountability, providing guidance, and following up. Lastly, the communication with impact competency involves predominantly behaviors pertaining to

sending messages—delivering clear messages, using visual aids, and creating clear written communications. The nursing leaders in this study identified listening, follow up, and follow through as key communication skills. This document holds them accountable to demonstrate these skills.

The Performance Management Plan asks the evaluator to document actual behaviors for each of the elements listed in Part I and Part II. The evaluator also rates the individual on degrees of achievement for the elements. This information provides data for creating a Developmental Plan, Part III. The Developmental Plan identifies competencies on which the individual will work within the agreed upon timeframe. Part IV of the document allows for ongoing feedback on progression toward set goals. Part V gives the employee and the leader an opportunity to make additional comments. Because the researcher reviewed this document after the interviews and focus group were completed, the nursing leaders did not have an opportunity to state whether this document provided them with valuable feedback on their performance.

During the focus group, the researcher presented the concept of *Culture of Accountability* based on the data gathered from the interviews. The focus group nursing leaders discussed how administration and corporate hold them to their productivity. When the researcher mentioned the expansive roles and responsibilities placed on the nursing leaders, such as core measures and quality improvement projects, the participants acknowledged this statement with both nonverbal and verbal agreement. These external forces place additional roles and responsibilities on the nursing leaders, sometimes taking them away from the staff and decreasing their visibility on the unit.

Administrative Support

This third subcategory describes the degree to which nursing leaders feel supported from higher administrators to perform their roles/responsibilities. Given the frequency with which senior leadership issues arose in the employee engagement survey, the researcher wondered to what extent the nursing leaders felt supported by senior leadership.

As noted by the staff, accessibility and visibility arose as an issue for the nursing leaders. Nursing Leader #12 stated, “Sometimes it’s hard for me to get an appointment with my boss. Their plates are full too.” Nursing Leader #4 indicated that the Chief Nursing Officer (CNO), to whom she reports, frequently cancels scheduled meetings with her. She indicated a degree of dissatisfaction with these canceled meetings because it limited her contact with the CNO and the ability for the CNO to provide her with feedback on her performance. She went on to say,

> At our annual evals, we never sat down with our boss to talk about that. And, that’s just one example. That’s my performance that we're talking about. That should be a priority. ‘You should be setting time aside to meet with us to discuss those. How are you really judging me on my performance if I didn't know what your expectations were to begin with? And how can I perform next year or going into next year and be evaluated next year, I still don’t know what is expected of me. I mean, what is it you need from me?

The focus group nursing leaders affirmed that this concept remains an issue and related its source to the administrators “being stretched too thin.” The discussion that followed described the challenges the administrators have in covering two campuses. One nursing leader gave a detailed example of the personal relationship that the chief nurse

executive had with staff prior to the merger of the two hospitals. These nursing leaders felt that the current two-campus format limited this personal relationship of the CNO with staff. In support of this concept, the nursing leaders elaborated by saying, “Once the place got bigger, it just changed, because you didn’t have that.” Referring to the table for *Behaviors & Attitudes,* the nursing leader commented, “You didn’t have your listening, follow-through, visibility, accessibility. All these things over here [under the Professional Domain], are just kind of out of reach, I think.” Another nursing leader commented that some staff would not be able to recognize members of the administrative team or know who they are. The seasoned nursing leader present in the focus group commented that in the years that she had been there that she had had “maybe twelve different reporting structures.” The group agreed that the current administrative team is “the stablest it has been for a while.” Another responded, laughing, “Well, that’s a good thing. I may not know who they are, but at least they are there.”

The group described how they met with HR after the employee engagement survey as a leadership group and discussed some of the issues. The Chief Executive Officer’s picture “is going to be in *Campus Connections* and he’s going to be sending e-mails out, and doing town hall meetings. They are working on it. They really are.” The discussion then turned to factors limiting visibility and accessibility of the administrators and the nursing leaders themselves. The biggest factors voiced pertained to the number of meetings they attend each day.

Although accessibility surfaced as an issue, the nursing directors felt able to reach senior leadership when really needed and that senior leadership listens to their concerns

and issues. Nursing Leader #1 indicated, “Sometimes it’s hard to get hold of them because they're all so busy, but for the most part, if I need something, I know I can get hold of somebody and get the answers that I need.”

Several nursing leaders felt that because they manage stable units, senior leadership does not view them as a priority. Comments from these nursing leaders included the statements,

- I'm never quite on their radar. I'm often skipped around the table too because everybody else seems to have more dramatic issues with staffing (NL #6).
- I wouldn't say it’s a lack of support. I just feel like sometimes my area is not priority (NL #14).

Several of the nursing leaders voiced satisfaction with the level of autonomy they experience. Nursing Leader #14 indicated, “I feel like I have some autonomy. I don’t feel like I'm micro-managed. I do feel like that senior leadership does ask for our opinions about stuff.” Several other nursing leaders in the interviews and in the focus group voiced satisfaction with not being “micro-managed.” They voiced having the “ear of administration” (NL #12) when needed. Nursing Leader #5 felt similarly in saying, “I have the ear of the CNO and the ANE’s [Associate Nurse Executive]…, I think they're always there for me. I try not to abuse them.” The nursing leaders do not, however, hesitate to call them when the need arises as Nursing Leader #9 stated,

> They've been really good, really good to me and any questions I've had, concerns I've had, anything that even no matter how minor it is, they've been really good about it, getting back with me and giving me feedback, giving me suggestions.

Nursing Leader #16 sums these two concepts, support and autonomy, up in this manner,

> My leadership team has that confidence in me as a leader that I'm also going to access them when I need to. And for me as a leader, it's important that I'm empowered to make decisions, and that I have the trust of my upper leadership team that I have that knowledge, skill and ability and allow me and empower me to do those things. And, when I can't that I know when to access them as well. So it's two fold, not only do they support me, but I that know enough when I need to access them.

The nursing leaders described a strong network of peer support when it came to day-to-day operations and unit management. Many stated they knew "who to call" and who their resources were. A nursing leader with less than one year in her current positions stated, "I had a lot of support from other directors. [Leader's name] has been here a long time, was a big support" (NL #15). An experienced nursing leader commented, "And I think that the more networking you do within the facility, you soon build those networks, and your senior leadership you're using for your hot problems. You're not using them on a day-to-day basis. Therefore, when you do call them, you get a response" (NL #10).

The focus group leaders validated this concept during their discussion of the subcategory. The nursing leaders indicated that they did not feel the need to be "micro-managed" by senior leaders. In fact, they preferred to have the autonomy to manage their units as they think best. One nursing leader stated, "If we page someone, we can get them. I don't need someone standing by my side all the time. If they did, that would annoy me." The most experienced nursing leader present commented, "I have become self-sufficient....If I need them, I will go to them. Truthfully, I don't need their assistance very much." What surfaced in this discussion was the high level of support that these nursing leaders felt from each other. One nursing leader described the "director group as

close as it's ever been. It's not somebody trying to outshine the other ones to get somebody's attention." They described a cultural of collegiality and a "helping" environment. Supporting this concept, a nursing leader stated, "I can pick up the phone and call any one of them and say, 'I'm in deep trouble.' Or, 'I'm having a bad day.' The group we have now, it's not the 'all about me' people. We all stick together." One nursing leader described the nursing leadership team as a "sorority." Each of them felt like they knew whom to call within the nursing leadership team for what they needed.

None of the nursing leaders interviewed indicated feeling that senior leadership did not support them in their position; however, one nursing leader felt that education toward professional certification did not receive the level of support it should based on the hospital's desire to pursue Magnet status. This nursing leader attributed this perceived lack of support to budgetary constraints in which the hospital limits travel expenses.

During the focus group discussion of this theme, one nursing leader commented, "We've had varying levels of administrators—good and bad." When encouraged to elaborate on what made them "good," this nursing leader stated, "Being out there. Staff know them. People know who that individual is. They can engage with that individual and that individual isn't necessarily walking into an area and making false promises." This statement transitioned the focus group discussion to the last concept presented for the *Organizational Culture & Policies* category involving Administrative follow-through and follow-up.

Administrative Follow-through and Follow-up

This final subcategory characterizes the degree to which nursing leaders feel that senior administration adequately follows through on promises and follows-up on issues. This concept surfaced on many of the unit's employee engagement surveys from the staff. The nursing leaders voiced similar concerns about their perception of senior administration "doing what they say they are going to do." Nursing Leader #8 stated, "It's not a personal thing, but it's a team, they don't follow through with what they say they're going to do. They've been saying for 3 years they were going to fix it." She referenced how she was promised that her unit would not receive what she perceived as inappropriate admissions, yet it still occurred. She did, however, acknowledge that since certain processes had changed, the frequency had decreased.

As another example, Nursing Leader #6 stated, "They were items that were promised such as renovations, and I don't even mean verbally promised. They were promised like the designer board and everything was up there and a date was set to renovate. So, it was that much of a promise, and then they were told that they didn't have the money." She recounted the negative impact it had on the staff. She has since met with senior administrators about this issue. She reports that her concerns were "well-received" by the senior administrators, and she hopes the behaviors will change since, "Nobody that's sitting there working cares that it might be five years down the road," when the promises are made and the staff think it will happen much sooner.

Despite the challenges nursing leaders face with these external forces impressing upon them, they voiced overwhelming satisfaction with their role. The next section of

this category describes the nursing leaders' level of satisfaction with their role and with the organization in which they operate.

Nursing Leader Satisfaction

During the interviews, the nursing leaders voiced many challenges in carrying out their role and responsibilities. As a final interview question, the researcher asked them,

9. What else would you like to say about being a nursing director at [the study site] and your ability to influence staff retention?

In response to this question, most nursing leaders chose to express their feelings about the role. Many of the nursing leaders described the role of a nursing leader as "challenging," "hard work," "not easy," "stressful," or "tough." Comments on the nursing leaders' workload included:

- Because of all the things we're expected to do, it's hard sometimes. I know a lot of us take work home with us because we're unable to finish it here because you have, you're multi-tasking 5 or 6 things going on at one time (NL #2).
- It's challenging. Every day, every day is extremely challenging, every day. You always get thrown curve balls, and you just learn how to duck and dodge effectively and always make sure that you carry that positive attitude to the staff (NL #4).
- It's not an easy job (NL #9).
- We have the toughest job (NL #11).
- It's very challenging. It's different every day. And that's one of the things that I like about it is the fact that I come into a different situation daily (NL #13).
- The responsibilities have increased and there have been fewer people to help with what we do (NL #17).

When asked what kept them coming back day after day, responses included:

- I enjoy my job. I've been here 9 years almost. So, don't have any plans to go anywhere else. Most of the time, it's a good place to work. We have our challenges some days, but for the most part, I've enjoyed it (NL #1).
- 99% of the time I like my job…it is very rewarding (NL #6).

- It was really great to come back to where I started. And, I want the unit to be the best and that is my goal. So, I mean, I just enjoy what I do. And I care about the patients, I round on the patients every day and when they're here, I want them to have the best care (NL #9).
- Because I think this is an important role. It's important to the staff, the administration, and it affects so many people (NL #12).
- Because I love what I do. I really do. I love the people that are here. I think that I make a difference (NL #13)
- The people that are here. And knowing that it's the right thing to do (NL #17).

The nursing leaders also participated in the employee engagement survey conducted May 2008. Human Resources provided the researcher with results from this survey. For the nursing leaders employed at that time, 100% indicated satisfaction with their job. The overall engagement score for this group was 81%. The interviews and the engagement survey appear congruent.

Validity and Credibility of Findings

The researcher took numerous steps to increase the validity and credibility of the data from which the findings emerged. Reflexive analysis entailed utilization of a field log in which the researcher described actions and rationale for decisions made throughout the data collection and analysis process. The researcher reread field notes containing thoughts, perceptions, and interpretations of the data. The researcher used these notes to journal potential biases.

To increase validity of the data, the researcher verified the transcripts with the audio recording prior to sending the transcript to the participant for member checking. Member checking also occurred during the interview process in which the interviewer paraphrased back to the participant and asked for validation of interpretation of what the

participant said. The verified transcript was coded and then re-examined after the completion of all transcript coding to determine if the data fit in a code generated later or was still appropriate. The researcher then systematically compared the codes from which five major themes emerged from this process.

In addition to the above strategies to enhance validity and credibility, the researcher presented the focus group with the findings and the model generated from the data. The researcher asked the nursing leaders whether they felt that the model accurately described their "world." Response from the participants indicated that the model accurately represents what they experience. The participants offered positive feedback on the results and thanked the researcher for the information. Comments included, "It's my little world," "It's very good," and "You've done a beautiful job." The participants especially like the breakout of Behaviors and Attitudes into the Administrative and Professional Domains, feeling like this information is a "great help." The researcher reiterated that the handouts presented during the focus group include the preliminary analysis of the data and that the participants could take this information, reflect on it, and then contact the researcher if they had additional comments.

Conclusion

The study sought to learn frontline nursing leaders' perceptions of behaviors and attitudes that influence staff retention. The data collected from multiple methods provided the researcher with sufficient information to answer this question. The predominant behaviors voiced by the participants were categorized into two subcategories, administrative domain and professional domain. The professional domain encompassed

the behaviors and attitudes pertaining to interpersonal skills. The most frequently mentioned competency related to communication, particularly the listening component.

From the data for the first research question, two other interrelated themes emerged—Employee Factors and Turnover. The theme, Employee Factors, incorporates four concepts—job satisfaction, family/life circumstance, educational development, and career development. These employee factors influence whether an employee stays in a position or leaves, creating turnover. While the nursing leaders offered multiple reasons for staff turnover, five primary reasons emerged. These reasons include moving, growth opportunities, positive turnover, competition, and compensation. Positive turnover describes situations in which the nursing leader either intentionally created turnover or chose not to dissuade the employee from leaving once intent to leave was voice.

The second question this study sought to answer pertained to nursing leader training and development. The nursing leaders described multiple methods by which they prepared for the position. These methods included classes from Organizational Development, courses in a degree program, on-the-job training, trial and error, mentors, and finally, “not much” preparation or orientation. The two factors that positively influenced nursing leader comfort when transitioning to the position include previous experience as a leader and previously working on the unit where they eventually became the leader. Eleven of the nursing leaders felt nursing leaders should have at least a Bachelors degree, whereas, five nursing leaders felt a Masters should be the entry level of leadership. The nursing leaders offered numerous suggestions for training and developing new nursing leaders.

As a tangent to the four themes already mentioned, a fifth theme emerged. The fifth theme, *Organizational Culture and Policies*, determines the context or environment within which the nursing leaders function. Four subcategories for this theme emerged: Productivity, Staffing Ratios; Culture of Accountability; Administrative Support; and Administrative Follow-through and Follow-up. These subcategories represent the external forces exerted on the nursing leaders that influence decisions they make within their units. Despite the many challenges the nursing leaders described, they voiced a high level of personal job satisfaction.

In Chapter Four, the researcher presented the data collected to answer the research questions without interpretation or discussion of the findings. The goal of this study was to create a theory or model on nursing leadership and staff retention. The results presented above indicate the multi-faceted nature of nursing leadership and its influence on staff retention. Chapter Five presents the model generated from the data and themes that emerged as well as a discussion of these findings.

Chapter 5 Summary and Discussion

Introduction

This final chapter restates the problem statement and provides a brief overview of the major data collection methods used in the study. As a major focus of this chapter, the researcher summarizes the results and discusses their importance and implications. The chapter concludes with suggestions for future research.

Statement of the Problem

Multiple factors contribute to the nursing shortage. Alleviating this shortage involves targeting recruitment and retention. The literature suggests focusing on retention as an advantage point. Retention poses a multifaceted problem in which nursing leadership surfaces as a key issue. Frontline nursing leaders directly oversee the largest employment population in a healthcare facility and maintain responsibility and accountability for the operations of individual patient care areas. Nursing leaders, by their behaviors and attitudes, can influence staff nursing turnover and intent to stay. However, limited formal studies exist on these frontline nursing leaders and the behaviors and attitudes that contribute to retention. Therefore, this study explored the perceptions of frontline nursing leaders in an acute care community hospital of behaviors and

attitudes that contribute to retention of staff nurses. In addition to this central focus, this study sought to answer the additional question, “To what extent do nursing leaders feel current leadership education and training programs support practices that promote staff retention?”

Review of the Methodology

The researcher designed the study for qualitative data collection and analysis using grounded theory. This methodology was chosen to increase knowledge of the views, values, and beliefs of frontline nursing leaders. Following a phenomenological perspective, the researcher sought to understand the frontline nursing leader’s viewpoint and meanings of these lived experiences.

Data sources for this study included the perceptions of nineteen frontline nursing leaders in a large suburban, two-campus, acute care community hospital in central Virginia. The nursing leaders interviewed received written and verbal information about the study and provided verbal and written consent. The researcher assured confidentiality as part of the recruitment and informed consent process. IRB approval was obtained from the study site and the researcher’s university prior to data collection.

Data collection to learn the nursing leaders’ perceptions entailed a single researcher conducting face-to-face, semistructured interviews using an interview guide. The researcher conducted the interviews in the nursing leaders’ natural environment. All interviews were audio recorded with participant permission and transcribed. Interviewees reviewed and validated the transcripts.

Additional data sources included information obtained from the site's Human Resource department on staff turnover, the number of Full Time Equivalencies (FTEs), and nursing leader satisfaction and engagement scores. The Human Resources department also provided the researcher with a template of the nursing leader annual performance evaluation and job description. The site's Organizational Development department provided the researcher with information on leadership development classes offered on-site for 2007 and 2008 and how many of the nursing leaders attended each of these sessions.

The researcher used inductive data analysis to analyze data collected. Using a grounded theory process, the researcher organized, categorized, and identified emerging themes from the data. A focus group of nursing leaders, who also participated in the interviews, validated the model generated from this process. The next section presents the model and summarizes the findings.

Summary of the Findings

Based on the experiences and perceptions of the study participants and data collected from HR and OD, major categories and subcategories emerged. Five major themes emerged: Behaviors and Attitudes; Employee Factors; Turnover; Organizational Culture and Policies; and Nursing Leader Training and Development. The Behaviors and Attitudes theme consisted of two subcategories, Administrative Domain and Professional Domain. The Employee Factors theme included four subcategories: job satisfaction; family/life circumstances; educational development; and career development. These subcategories influenced whether an employee chose to stay in a position or leave a

position, creating Turnover. The fourth theme, Turnover, encompasses the employee factors prompting staff to leave as well as situations in which the nursing leader intentionally creates turnover. The nursing leaders provided numerous examples of situations in which they created "positive" turnover. The Organizational Culture and Policies theme describes how the context and culture in which the nursing leaders operate influence the decisions they make. Four subcategories emerged for this theme: Productivity, Staffing Ratios; Culture of Accountability; Administrative Support; and Administrative Follow-through and Follow-up. The Nursing Leader Training and Development theme described the perceptions of nursing leaders on ideal level of academic preparation, described nursing leader preparation for the position, and offered suggestions for nursing training topics to equip them to focus on and improve staff retention. Figure 4 denotes the model generated from the data. The next section provides a discussion on the interrelationship of the themes and links these findings to previous research on nursing leadership competencies as manifested through the nursing leaders' behaviors and attitudes.

Discussion of the Findings

In the discussion of the findings section, the researcher offers insights into the interpretation and meaning of the study findings. The next section examines how the findings expand the body of knowledge within the context of previous research on nursing leadership competencies.

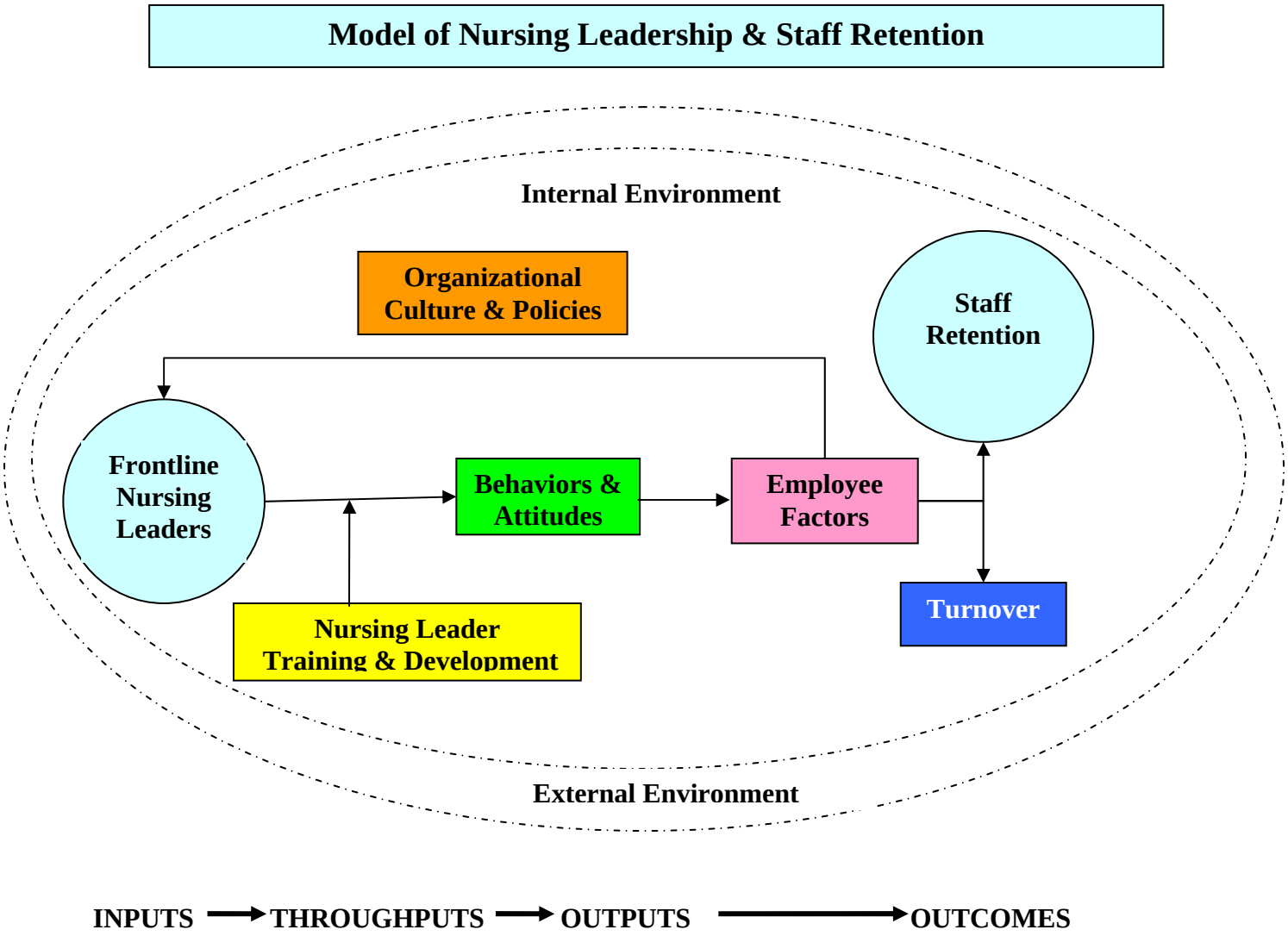

Figure 4. Model of Nursing Leadership & Staff Retention. This model depicts the interrelationship of five major themes influencing nursing leaders and staff retention.

Interpretation of the Findings

In this section, the researcher interprets the data within a systems theory conceptual framework. As described in Chapter 3, system theory examines *inputs*, *throughputs*, and *outputs* within the context of the internal and external environment of the organization. For this study, nursing leaders function as *inputs.* The Nursing Leader

Training and Development theme emerged as influence on and has the potential to create change in nursing leaders. This theme influences the behaviors and attitudes the nursing leaders exhibit, the *outputs.* The outputs can be benchmarked through measuring staff retention and turnover, the *outcomes*.

Nursing leaders in the study site are held accountable for meeting these benchmarks through Organizational Culture and Policies existing as part of the system's internal environment. The nursing leaders and nursing staff exist and operate within larger systems or environments. Part of the internal environment exerting influences on the nursing leaders is the unit for which they have oversight. Variables determining the internal environment include size of unit, number of patient beds, services rendered, and unit culture. In addition to unit specific variables, the internal environment encompasses the Organizational Culture and Policies within which the nursing leaders function. Another aspect of the internal environment influencing decisions nursing leaders make include the organizational mission and vision, and organizational structure. This study did not explore components of the external environment which include the larger multi-organizational corporate culture and policies, healthcare regulatory bodies' expectations (e.g. The Joint Commission), and characteristics of patient populations served by the study site (e.g. socioeconomic factors of patients using the services).

Because of the multiple variables, systems theory does not assume a linear process. Multiple factors and variables act on the nursing leaders and on employees simultaneously. The Internal Environment, Organizational Culture and Policies, influences both the nursing leaders and the employees. Accountability flows from the

senior administration down to the employees through the nursing leaders. When using a systems perspective to explore how nursing leaders' behaviors and attitudes influence staff retention and turnover, Employee Factors must be considered.

The nursing leaders' behaviors and attitudes filter through the Employee Factors, which serve as mediating variables. The four subcategories in the Employee Factors theme describe potential situations in which an employee may choose to leave a unit even in the presence of effective leadership. For example, the employee has the option to chose to comply with organizational policies or not. An effective leader holds all employees accountable of these policies in a fair and consistent manner. If an employee chooses not to comply, the effective nursing leader takes disciplinary action. This disciplinary action can result in voluntary or involuntary termination of the employee. The employee's actions serve as a feedback mechanism influencing the behaviors exhibited by the nursing leader. Removing difficult employees from a work team increases job satisfaction in the remaining team members. The employee may also choose to stay in a unit because of the positive influence of the nursing leaders. While the nursing leaders' behaviors and attitudes can serve to directly influence whether the employee stays or chooses to go, the nursing leaders' behaviors may also have no bearing on the employee's decision, in which case the rationale may stem from one of the other factors identified in the study.

The model depicts how the Organizational Culture and Policies and Nursing Leader Training and Development influence nursing leaders' behaviors and attitudes. These behaviors and attitudes then act upon and are filtered through the employee. These

interacting variables in conjunction with the internal and external environments have the potential to influence staff retention and turnover.

Nursing Leader Preparation

Academic preparation.

Since Nursing Leader Training and Development can determine whether an individual seeks or is promoted to a leadership position, the discussion starts with this theme. The road to becoming a registered nurse (RN) can vary greatly. There exist three educational routes for preparing to sit for the National Council Licensure Examination for registered nurses (NCLEX-RN): Diploma program; Associate Degree in Nursing (ADN); and Bachelor of Science in Nursing (BSN) program.

According to the 2004 National Sample Survey of Registered Nurses, 31.7% held a BSN. The largest percentage (33.7%) of the nurses surveyed held an ADN. Only 8.8% of the nurses participating in this survey held a Masters of Science in Nursing (MSN). While Virginia statistics are not available for how many RNs hold the varying levels of degree, some telling statistics are available. Of the nurses graduating in 2008, approximately 40% earned a baccalaureate degree. This fact has implications for the future pipeline of nursing leaders if hospitals intend to apply for Magnet Status. By January 1, 2011, 75% nursing managers must have a BSN in order for a hospital to qualify for Magnet (ANCC, 2008).

Most participants in this study felt a BSN should be minimum requirement for a frontline nursing leader. Some felt a MSN would be helpful, but did not feel it should be

a requirement. Recommendations for level of education tended to reflect the level of education the nursing leader possessed. Kleiman (2003) found similar results in her study with nursing managers and nursing executives. The nursing leaders advocating for a MSN stressed the magnitude of the difference obtaining the degree made. Nursing Leader #16 entered nursing with an ADN, and went on to earn a BSN and MSN. When asked how the education made a difference in her current role, she responded, "I am definitely not the same person with the AD. I have totally; I think it broadened my view. It gave me a more global perspective about how everything works." The transformation this nursing leader described is also described in the Swedish study conducted by Lindholm and Uden (2001). Their study showed a difference in perception of how the nursing managers handled their role after completing the graduate training program. Anthony et al (2005) found that the nursing leaders with masters degrees espoused a more global perspective of the nursing leader role. Almost half the participants in Scoble and Russell's study (2003) recommended a MSN. This relatively high percentage when compared to other studies may be attributed to the participants who completed Scoble and Russell's survey. Participants comprised of attendees at the Institute of National Healthcare Leaders. Attendees of this meeting generally hold the job position of faculty, dean, nurse executive, graduate student, or nurse manager. It is likely that these attendees possessed a graduate degree and therefore advocated all nursing leaders attain a graduate degree as well, not unlike those with a graduate degree in this study.

The expanded role of the nursing leader necessitates having a broad spectrum of leadership skills in addition to clinical skills. The previous paradigm of hiring nurses who

demonstrate clinical proficiency is no longer sufficient. As the nursing leaders in this study indicate, clinical competence comprises only a small segment of the multi-faceted role of frontline nursing leaders.

Training and development.

As organizational structures flatten, frontline nursing leaders experience an increase in role responsibilities. The increased demands on the frontline nursing leaders translate into a need for training programs for this level of leadership. In describing the training needs of new frontline nursing leaders, the participants offered an array of topics as described in Chapter 4. The top training or learning needs identified by the nursing leaders are listed in Table 15 in Chapter 4. The findings of this study corroborate the findings of Sullivan et al (2003) for most elements recommended for new nursing leaders. Added to the list generated by Sullivan et al are accessibility and visibility, team building (staff and leadership), and coaching and mentoring staff. This slight variation in recommendations may be attributed to the differences in study participants. Sullivan et al. included multiple levels of nursing leadership although the results targeted frontline managers in an academic setting, whereas this study drew data only from frontline nursing leaders in a community setting. Sullivan et al also did not focus on the behaviors and attitudes most likely to influence staff retention.

As with the participants of this study, most of the frontline nursing leaders do not possess advanced degrees (Masters level), leaving to question what is the best way to train them in this broad array of skills necessary to do their jobs effectively. Porter-O'Grady (2003) emphasizes the importance of surveying the changing environment and

re-evaluating the skill sets nursing leaders need. The healthcare environment is rapidly changing. Patients and families depend less on the healthcare provider for information, choosing instead to rely on information found readily on the internet. Technology continues to advance at an astounding pace. As changes occur within and outside the healthcare environment, systemic changes occur that influence delivery of care and ultimately, impact staff. Nursing leaders need skill sets that facilitate assessment and management of the environment. The question remains, how should nursing leaders attain these skills?

To train the leaders "in-house" requires having educators with the appropriate leadership skills and knowledge, space to conduct the training, and availability of the participants. The nursing leaders in this study voiced several challenges to attending scheduled in-house programs. The greatest barrier to attending continuing education, and for going back to school for a higher degree, was time. The nursing leaders recommended having shorter programs, such as two hours in length versus four-hour or longer programs. Longer programs decrease their availability and visibility on their unit.

In order to address the educational needs of frontline nursing leaders, the American Association of Critical Care Nurses (AACN) collaborated with the American Organization of Nurse Executives (AONE) to create *Essentials of Nurse Manager Orientation,* the "first leadership course created specifically for nurse managers" (aacn.org). Launched fall of 2008, this web-based self-learning training program specifically targets frontline managers and leadership staff. In the HRM module, the program dedicates a section to retention, covering understanding turnover and strategies

for retention. The inclusion of a section dedicated to retention demonstrates national nursing organizations' recognition of retention as a vital function of the frontline nursing leader. This web-based program offers nursing leaders an alternative to classroom instruction and offers flexibility in completion of the course requirements.

In addition to formal learning and training programs, the study participants acknowledged the role and importance of mentoring and having an adequate orientation. The next section discusses these elements for training new nursing leaders.

Orientation .

Trial and error served as a predominant method for novice managers to learn the role (Sherman et al, 2007). Like the leaders in Sherman et al's study, the nursing leaders in this study spoke frequently of receiving little or no orientation. One nursing leader in this study, when asked about orientation, responded, "Here's your chair, go for it" (NL #15). The nursing leaders in this study, like other studies (Sullivan et al., 2003) identified the need and desire for a formalized orientation plan and mentoring program. In one interview, and also during the focus group, nursing leaders referenced an orientation plan developed a couple of years ago that was never implemented. Formalizing the orientation and providing the new nursing leader with a mentor decreases "trial and error" as a primary mechanism of learning and facilitates the building of strong collegial networks among the nursing leaders. Several leaders in this study voiced willingness to mentor new leaders even though it would put additional role strain on them. Most nursing leaders spoke favorably about their mentors. The few negative comments expressed about mentoring pertained to access to the mentors. This concept should be considered when

mentors are chosen, and mentors should be on the same campus if the organization has more than one campus or site.

Several nursing leaders in this study recommended spending time on the mentor's unit prior to assuming operational responsibilities for their own unit, thus allowing them to focus on skill and knowledge acquisition without the onus of managing the day-to-day tasks on their own unit. Spending time with their mentors builds strong relationships and eases the novice or new nursing leader into the role. The Chief Nursing Officer (CNO), as the senior nursing administrator, is in the best position to match the new leader with a peer mentor. The new leader should also spend time with the CNO in order to learn what the CNO position entails and how the nursing leader position supports the overall mission of the organization. The CNO can offer a more global perspective than a peer mentor. Initially, the CNO should plan to meet frequently with the new nursing leader to determine progress in learning the role and responsibilities.

Conclusion.

The nursing leader plays a critical role in enhancing quality patient care and patient care safety through staff retention skills (Mathena, 2001; Sullivan et al, 2003; Wong & Cummings, 2007). The results of the analysis of seven quantitative research articles done by Wong and Cummings (2007) showed a link between positive leadership behaviors and patient outcomes related to patient satisfaction and a reduction in adverse events. By developing evidence-based nursing leadership training programs, academic and institutional, nursing leaders will be better equipped to face the challenges of their multifaceted roles now and in the future. Equipping nursing leaders with the skills

necessary to influence retention will increase their effectiveness as a leader and ultimately impact the quality and safety of patient care (Mathena, 2001). The correlation of nursing leaders' behaviors and attitudes, staff retention, and quality of care cannot be ignored (Levack & Jones, 1996). Although a Masters degree has been recommended (Kleinman, 2003), the 24/7 accountability and role demands inhibit many nursing leaders from pursuing advanced degrees. Organizations have a responsibility to provide nursing leaders with educational programs to address the key competencies identified that influence retention. Effectiveness of institutional leadership training programs can be measured by observing nursing leaders' behaviors and attitudes. Are nursing leaders implementing the skills taught? Outcomes can be measured through national benchmarking standards (e.g. Leapfrog), organizational core measures, turnover (voluntary and involuntary), and patient, staff, and physician satisfaction scores. By giving nursing leaders the tools to perform effectively in their role, organizations also increase nursing leaders' job satisfaction, thereby lowering turnover in leadership.

Behaviors and Skills

Comparison of study findings to previous studies.

The findings of this study suggest key behaviors and attitudes of nursing leaders influence staff retention. The majority of the behaviors and attitudes identified by the study participants as important influencers of staff retention also appeared in the literature review of general skills, knowledge, and attributes that nursing leaders need to possess although the exact terminology varied slightly. Tables 16 and 17 below duplicate the

tables presented in Chapter 2. The competencies bolded represent the skills, knowledge, and attitudes the study participants identified as important influencers of staff retention.

Table 16. Competencies for Nursing Leaders: Comparing Study Results with Literature Review

Professional Domain	
Relationship with Staff	**Personal Mastery**
Communication	Visioning
Coach, Mentor, Role Model	Decision making
Staff Development	Professional Development
Team Building	Analytic; Systems thinking
Change Agent	**Clinical Competency**
Empowerment	Time Management
Social Awareness	Ethics

Note: competencies in bold represent those identified by the study participants that influence staff retention

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Table 16. Competencies for Nursing Leaders: Comparing Study Results with Literature Review (Continued)

Administrative Domain			
Manager Role	**Human Resource Management**	**Fiscal**	**Outcomes**
Staffing	**Retaining Staff**	**Budget**	Patient Focus
Safety	**Hiring; Recruiting**	**Balance Cost & Quality**	Research; Evidence-based Practices
Technology; Information Management	**Cultural Competence**	Payroll	Quality Management Process Improvement
Political Savvy	**Recognition; Praise**		**Staff Satisfaction**
Regulations	**Performance Feedback**		Risk Management
Problem solve; Negotiation	**Discipline**		MD satisfaction
Strategic Planning			

Note: Competencies in bold represent those identified by the study participants that influence staff retention.

Table 17. Attributes of Effective Nursing Leaders: Comparing Study Results with Literature review

Flexible	Trust	**Honesty/Integrity**
Empathy/Caring	Respect	**Fair/Consistent**
Passionate/Committed	Motivated	Creative/Innovative

Note: Competencies in bold represent those identified by the study participants that influence staff retention.

The nursing leaders identified "advocate/liaison" as important. This behavior most closely relates to *Political Savvy* in the table above. Anthony et al (2005) termed this behavioral concept "championing the nurse." "Follow through" and "follow-up" most closely align with the "problem solve" and "negotiate" skills listed above. The attribute "positive" aligns with "passionate/committed." Nursing Leader #2 in describing what it takes to be an effective leader indicated, "[It is] your love and passion to do the job, and if you don't have passion to do your job, no matter what education you have, you're not going to be successful." This study by no means discounts the skills, knowledge, and attributes (SKA) not identified by the participants. The study participants identified those they perceive as influencing staff retention or turnover. The purpose of this study was not to identify an all-inclusive list of SKA for the general frontline nursing leader role.

The participants in this study identified three attributes also identified by Anthony et al (2005), one of the few studies specifically targeting frontline nursing leaders and retention. These common attributes included flexibility, fairness/consistency, and

honesty. Behaviors common to Anthony et al and this study include coaching/mentoring, team construction (building the "right" team), fiscal responsibilities, communication, listening, interpersonal relationships, and advocating for staff. Most of the studies reviewed on nursing leader competencies identified communication and interpersonal skills as critical (Anthony et al, 2005; Mathena, 2002; Sherman et al, 2007; Strachota, 2003; Sullivan, Bretschmeider, & McCausland, 2003; Wong & Cummings, 2007). What these studies do not do, with the exception of Anthony et al., is directly tie nursing leader competencies to staff retention. The next section briefly discusses some of these key behaviors and skills identified in this study and substantiated by previous studies.

Communication and listening.

Like the leaders in this study, the leaders in Manion's (2004) study suggest keeping communication open and honest. The nursing leaders made efforts to present presumably unpleasant news to the staff with "a positive twist." They often took a "cheerleading" stance or a "we can do this" stance, giving the staff the perception that they were "in it together." The nursing leaders identified "keeping the nurses satisfied, just keeping their morale up even on tough days" (NL #8) as one of their greatest challenges. Another nursing leader echoed this sentiment in saying, "I think the biggest challenge would be keeping the staff happy and positive even on the worst of days to make them want to come back tomorrow. And you can be the best cheerleader in the world, but it's very hard to be on positive when the situation is not good" (NL #19). In addition to open and honest communication, the nursing leaders stressed the importance

of listening to the staff and following-up with their concerns. Nursing Leader #14 described the process this way,

> I have an open-door policy, that I listen to staff issues and concerns, try to address them in a manner for which they feel is appropriate. Sometimes they don't feel what I am addressing is appropriate but in the grand scheme of things, I have HR issues that I have to maintain so therefore I try to also let them know that their issue has been received and is being addressed.

Manion (2004) described similar comments in her study with frontline nursing leaders.

Another aspect of communication that emerged pertained to information dissemination. The employee engagement survey indicated that much of the staff did not feel that they knew or understood what was happening in the organization. The nursing leaders voiced ways in which they felt they could improve communication from senior administrators to the staff. Strategies for communication include monthly staff meetings, unit-based newsletters, communication book, staff "huddles," posters, memos, e-mails, and communication boards. The site's administrators have taken an active approach to improving this communication to the staff. Administrators have attended staff meetings, held open forums, and created a "Dear CEO" column in the hospital newsletter. All of these strategies illustrate a willingness on the part of the nursing leaders and senior administrators to address a need identified by the staff on the employee engagement survey. The 2009 survey will provide a measurement for effectiveness of these strategies.

Visibility and accessibility.

The nursing leaders in this study strongly felt that interpersonal skills and accessibility play a critical role in staff retention. Strong interpersonal skills build relationships with staff. The nursing leaders develop authentic relationships with the staff by spending time with them and getting to know them through individual interviews and learning what is happening in their lives. By being visible, the nursing leaders gain a better understanding of the challenges the nurses on their unit face. Being accessible enables the staff to communicate needs to the nursing leaders more readily. Sherman et al. (2007) found this concept true for their study participants as well. Visibility and accessibility posed a greater challenge for nursing leaders of large units. The nursing leaders offered suggestions for increasing accessibility through e-mails, pagers, home phone numbers, blackberries, and "team huddles." Manion (2004) suggests these strategies aid in creating a culture of retention. Being accessible and visible on their units also allowed the nursing leaders to model the behaviors they expected of the staff.

Empowerment.

Manion (2004) states, "One of the most influential ways these managers get results is by empowering and involving their staff members" (p. 36). The nursing leaders frequently talked about involving the staff in decision making, from equipment purchases to hiring staff. Elements of shared governance permeated the examples offered by the nursing leaders. Ellenbecker, Samia, Cushman, and Porell (2007) found a positive correlation between job satisfaction and shared governance in their study on retention with home health nurses. The *Wisdom at Work* study also identified autonomy and shared

governance as important strategies for retaining older, experienced nurses (RWJF, 2006). Older RNs fit into the "sandwich" generation in which they care for multiple generations. Proactive organizations assess the needs of these workers and offer options, such as childcare, eldercare, flexible scheduling, and phased retirement. The *Wisdom at Work* document identified twelve best practices for retaining older workers. Of these 12 best practices, there exist several practices within the control of nursing leaders to implement or support:

- Offering flexible work options
- Instituting mentoring programs
- Assessing and understanding workforce strengths and needs
- Offering training, lifelong learning, and professional development
- Improving ergonomics and workplace design

With the RN workforce aging, organizations implementing these identified best practices will slow the exodus of older nurses and possible stem the brain-drain. Although the nursing leaders in this study acknowledged this concept as important and spoke to wanting to do more for their "seasoned" staff, few offered specific suggestions. This concept surfaces as an area of opportunity for the nursing leaders at the study site.

Clinical competency

Many of the nursing leadership roles identified in competency-based education programs pertain to leading the staff and managing the environment. Nursing Leader #17 indicated that managing the environment inhibited her ability to remain clinically competent. Anthony et al (2005) also reported this finding. Despite the multiple role demands decreasing nursing leaders' visibility and accessibility to staff, many of the nursing leaders in this study stressed the importance of the helping role and how

remaining clinically competent strengthened their relationship with the staff. Manion (2004) tied visibility to "jumping in and helping" as an important role for nursing leaders in creating a culture of retention. Nursing leaders in this study frequently talked passionately about working along side their staff and demonstrating willingness to do what they ask the staff to do. Scoble and Russell (2003) emphasize the importance of nursing leaders having clinical experience within the area in which they are leading. The ability and the willingness to work along side the staff demonstrates a caring attitude, builds credibility, and provides the nursing leaders with the opportunity to assess staff competency and determine educational needs.

Attributes.

Many of the studies on nursing leaders and retention focus predominantly on the administrative domain competencies, style of leadership (Wong & Cummings, 2007) or specify a generic need for "Interpersonal skills" (Mathena, 2002). Sherman et al (2007) dedicates a core competency statement to "caring." Manion (2004) conducted a study to determine what nursing leaders did to create a culture of retention. As with this study, Manion's study found caring to be a significant factor. In both studies, the nursing leaders demonstrated and verbalized a positive regard for their staff. Anthony et al (2005) identified two of the same attributes the study participants mentioned, fairness/consistency and honesty. Although the professional domain contains fewer elements than the administrative domain, it forms a critical foundation upon which nursing leaders build their team and helps to create the affective environment in which the nursing leaders and staff operate.

Administrative domain: Managerial role and human resource management.

Many of the managing the environment roles described in previous studies (Sherman et al, 2007) and in competency-based nursing leadership programs address the concepts of the managerial role and human resource management roles. These two concepts interrelate. Providing and monitoring staffing consumes much of the nursing leaders' time and energy. Nursing leaders spoke frequently about staffing and staffing ratios as a significant challenge for them and as a top reason for staff dissatisfaction. The human resource management role entails recruiting, interviewing, and hiring. Without skills in this area, the nursing leaders struggle to find "the right" people for their units. Manion (2004) concurs with the findings of this study in that technical skills are not necessarily the most important characteristic of a prospective employee. Nursing leader #5 spoke about the hiring process, saying she focuses on

> continuing to recruit really good people. Fine tuning my interviewing skills to try to recognize those that are going to be a great fit and those that may not be. You just can't hire a body; sometimes, you're really going to have to suffer through your staffing shortage to make sure that you're hiring the right people to retain them.

Helping staff to understand this process becomes important, especially in times of critical staffing shortages. Not everyone with a pulse should be hired. Once hired, nursing leaders must ensure that the new orientee receives an appropriate orientation and any required training and development needed to competently care for patients within the unit's scope of care. Just as it is essential for the organization to provide nursing leaders with the tools to competently perform their role, nursing leaders must ensure their nurses receive appropriate

training. Education and training increases staff job satisfaction and increases quality of patient care, thus improving outcomes. For those nurses demonstrating high quality patient care and professional behavior, recognition of these achievements also increases job satisfaction. Recognizing the nursing team for meeting core measures and achieving high patient satisfaction scores builds esteem and pride in the unit and contributes to unit cohesiveness. Members of a cohesive team are less likely to leave a position.

Effective leaders use a variety of these skills, behaviors, and attributes to promote staff retention through increased job satisfaction. The next section offers discussion on the perceptions the nursing leaders and staff job satisfaction.

Employee Factors

Determinants of job satisfaction.

The work of Sullivan et al (2003) and Upenieks (2002) support the significance of the nursing leader's influence on staff retention. In reviewing the data on employee job satisfaction and turnover, two-factor theory has applicability. This theory posits that job satisfaction and dissatisfaction stem from different variables. *Motivators* promote job satisfaction, whereas, dissatisfaction with a job stems from *Hygiene Factors.* Table 18 differentiates the variables for each of these groups.

Table 18. Two-factor Theory

HYGIENE FACTORS	MOTIVATORS
Quality of supervision	Promotion opportunities
Pay	Opportunities for personal growth
Company Policies	Recognition
Physical working conditions	Responsibility
Relations with others	Achievement
Job security	

Source: Greenberg, J. & Baron, R.A. (2003, p. 153).

The nursing leaders offered multiple examples of hygiene factors as a source of employee dissatisfaction. When the nursing leaders held staff accountable for following company policies, some opted to voluntarily leave the organization rather than change their behaviors. For other employees, the nursing leaders spoke of terminating them for not following company policies. Compensation rose frequently as a reason for staff leaving to go to other facilities.

The nursing leaders spoke frequently of supporting personal growth and development. Although staff development increases employee satisfaction, within healthcare, it can also serve as catalyst for an employee to leave a unit. Several of the telemetry and intermediate care unit leaders referred to their unit as a “training ground” for staff before they moved to a higher level of care such as an Intensive Care Unit. One nursing leader lamented three staff members leaving “to go to [the other campus] in management positions. And I couldn’t offer that here” (NL #12). When unable to meet the employee’s need for growth or the desire for promotion, the employee is likely to leave to fulfill this need.

When the nursing leader can promote growth within the unit or provide opportunities for increased responsibility, motivation to stay increases (Manion, 2004). Nursing Leader #2 described some of the changes she implemented when she moved into the position to increase staff responsibility. She indicated the staff responded with "'Oh, my gosh, you did the best thing'… all she wanted was responsibility." The nursing leader's willingness to share responsibility and decision making with the staff increases staff satisfaction and retention (Strachota et al., 2003). Focusing on the motivators serves as an advantage point for increasing staff satisfaction leading to retention.

Job satisfaction.

Sherman et al (2005) identified recruitment and retention as a major challenge for nursing leaders. Likewise, the study nursing leaders indicated their biggest challenge was meeting staff needs and keeping them happy and satisfied. Like previous studies, staffing ratios emerge as a major dissatisfier for staff (Strachota et al., 2003). This study corroborates Strachota et al's findings that staff perceive the workload as being too heavy. This fact gives credence to the enduring nature of the nursing shortage that six years after Strachota et al's study, the same issues remain. By increasing job satisfaction, nursing leaders decrease the potential for turnover related to this concept (Gould et al, 2001). Nursing leaders can focus on the *motivators*, such as staff development, recognition, and responsibility. These factors remain within the nursing leaders control.

An independent factor outside the control of nursing leaders is level of education of the nurse. Zurmehly (2008) showed a positive correlation between level of education and job satisfaction. Nurses with a BSN expressed higher satisfaction than ADN or

diploma nurses. In the model used to test job satisfaction, educational level ranked third behind critical thinking and autonomy. While educational level may influence job satisfaction and retention, it is not within the nursing leaders' control. Creating and promoting opportunities for critical thinking and autonomy of practice, however, are within the nursing leaders' control and should be considered and implemented.

Other employee factors influencing turnover or intention to stay.

In addition to job satisfaction, the findings of this study revealed three other employee factors influencing whether staff stay or leave a unit. Of these factors, family/life circumstance and career development, also surfaced in the study by Strachota et al. (2003). Their ranking, however, varied. In Strachota et al's study, moving ranked at the bottom of the list, whereas, in this study, it was the number reason the nursing leaders' gave for staff leaving. The reason for this difference may pertain to the study participants (staff in Strachota et al.'s study versus nursing leaders) or it could also pertain to much larger system factors such as geographical location and economic outlook. The influence of the economy on nursing movement will be discussed later in this chapter. The third employee factor, Educational development, or staff development, arose as a staff satisfier as previously described and helps to promote staff retention. Sherman et al. (2007) describe providing staff with growth and development opportunities as a Human Resource management competency and the two-factor theory identifies it as a motivator for job satisfaction.

One factor infrequently mentioned in the studies reviewed is employee commitment to the organization. Organizational commitment focuses on the individual's

attitude toward the organization and his/her level of involvement and interest in remaining (Greenberg & Baron, 2003). The study site measures this level of engagement annually and reports these findings to the nursing leaders. The higher the level of employee engagement, the less likely the person is to leave the organization. Increasing staff involvement in decision-making and providing increased responsibility enhances organizational commitment. Older nurses tend to exhibit stronger organizational commitment (McNeese-Smith, 1999; Strachota et al., 2003). Organizational commitment is also strengthened through development of strong social relationships. The nursing leaders in this study described a strong network within the leadership group for supporting each other. Similar networks among staff strengthen the team and create a since of community (Manion, 2004). The nursing leaders also spoke about how they encourage this social interaction outside of the work environment.

These employee factors can either lead an employee to stay or lead the employee to leave a unit or organization depending on whether they are perceived by the employee as a motivator or as a hygiene factor. Many of the hygiene factors prompt the employee to leave. In the next section, turnover is addressed.

Turnover

Turnover rates.

In this study, the four areas into which the nursing leaders' units were grouped showed similar turnover rates. Unlike the study conducted by Strachota et al. (2003), the specialty areas did not show a higher turnover rates than other areas. In fact, several of the specialty areas indicated that the demand for positions in their unit is so high that they

do not have any open positions or currently have a very low turnover rate. One nursing leader described her area as a “niche” in which people tend to stay once they obtain a position.

In Strachota et al’s study (2003), they indicate hours worked as the primary reason for nurses leaving. This category included “working long shifts, overtime, weekends, nights, and holidays” (p. 114). The nurses at the study site predominantly work twelve-hour shifts, three days per week. Any overtime worked is voluntary. The nursing leaders infrequently mentioned work schedule as a reason for staff leaving. One nursing leader voiced concern for her older staff and their ability to continue to work 12-hour shifts as they near retirement age. Her concern pertained to the physical demands placed on the nurses with the increase in bariatric (morbidly obese) patient population. Another nursing leader referenced a nurse leaving because another facility promised the nurse a dayshift position. Not mentioned in Strachota et al’s study is the concept of “positive” turnover in which the nursing leader intentionally created turnover. Since Strachota et al’s survey comes from the perspective of the staff, this concept may manifest itself in the “Management was not supportive, expected the staff to go the extra mile but management did not” (p. 115) category. The next section discusses the nursing leaders’ perception of positive turnover.

“Positive” turnover.

The concept of “positive” turnover surfaced multiple times in this study. Marguis and Huston (2009) indicate that some turnover is “normal and, in fact, desirable” (p. 324). Whereas Marguis and Huston dedicate three sentences to this concept, the study

participants talked extensively about how, in order to create the right team for the unit, they facilitated and encouraged turnover. Retention studies frequently describe building the "right team" and "team construction" as a key competency of nursing leaders. The strategies offered generally pertain to hiring practices. While hiring the right people plays a critical role, nursing leaders also need to develop skills in creating the right team that involve performance management. Performance management involves holding staff accountable for meeting clinical standards and professional behaviors. When done well, nursing leaders offer positive feedback and praise. When staff fail to meet expected standards and norms, the study participants first tried coaching and counseling. If these strategies prove ineffective, the nursing leaders need skills in facilitating turnover, either voluntary or involuntary. Critical to this process is learning what documentation Human Resource requires and developing skills in having those "difficult conversations." Marquis and Huston (2009) in their book, *Leadership Roles and Management Functions in Nursing*, include a chapter on "Problem Employees." The chapter appears last in their book. Several of the nursing leaders in this study indicated that dealing with problem employees was a primary role when they first assumed the frontline leadership position. They described the need to provide consistent and impartial discipline when holding the staff accountable. Creating "positive" turnover surfaced as a legitimate retention strategy by increasing the satisfaction of the staff remaining and prompting some staff to return to the unit after the "problem employee" left.

Reasons for staff leave.

The nursing leaders offered slightly differing reasons for turnover than Contino (2004). Contino contends that the top three reasons for staff departure are "compensation, scheduling options, and intensity of work." Compensation arose as a factor in this study. Only one nursing leader suggested that a staff member left because of intensity of the work. This nursing leader indicated, "The one nurse that went to [unit], she was somewhat lazy. So, I think she was looking for a lesser patient-to-nurse ratio thinking that it would be easier on her. I don't think she was looking to increase her knowledge base." Strachota et al (2003) also examined reasons for staff changing positions. They found the top reasons were schedule, compensation, family reasons, and poor staffing. Scheduling surfaced infrequently in this study. None of the directors specifically indicated that staff left due to staffing ratios.

Conclusion.

Outcomes measurements bear witness to successful changes in practice (Porter-O'Grady, 2003). In order to accurately measure success in this domain, organizations must track voluntary and involuntary turnover separately. Additional factors, such as transfers for growth opportunities and "positive" turnover, should be acknowledged. Independent exit interviews can provide data on voluntary turnover and the influence the nursing leader had on this concept. Organizations must drill down what factors play a real, rather than perceived, role on staff turnover.

Organizational Culture and Policies

Systems theory requires the researcher to attune to the internal and external environment that influences *inputs*. Qualitative research produces contextually bound results because of environmental factors. The researcher interprets the results within the social, political, and cultural context of the environment in which the study was conducted. This section discusses the study findings acting as *throughputs* on the nursing leaders. These *throughputs* serve as external forces which the influence the nursing leaders' decisions, behaviors, and to some extent, attitudes. Given the contextually bound nature of these concepts, the researcher found few studies that explored these same concepts. In fact, three of the four concepts that emerged for this theme were unexpected findings for the researcher. The one that did not surprise the researcher was *Productivity; Staffing Ratios*. This concept will be discussed first.

Productivity; staffing ratios.

This concept, productivity and staffing ratios, describes the degree to which administrative control of productivity and staffing ratios influences decisions made by the nursing leaders. The nursing leaders in the focus group confirmed their challenge involves balancing productivity with staffing ratios and acuity.

The challenges the nursing leaders identified in this study reflect those found by Sullivan et al (2003). Leaders in both studies identified "staffing" as a challenging aspect of their role. The "tough days" occur when staffing and patient acuity run countercurrent. A nursing leader related her biggest challenge to staff retention back to "the level of

staffing and the workload. We don't have enough nurses to take care of these patients" (NL #4). Echoing this position, a nursing leader stated,

> My biggest challenge is making sure that my ratios are appropriate or the acuity and the ratios are appropriate for the staff to take. And as long as I can maintain that balance, I think my retention will stay up. When I can't maintain that balance, I think that's when the frustration comes in with the nurses. So, just making sure that we have the right mix, the right patient-to-nurse mix (NL #13).

Although nursing leaders identified staffing as a challenge to retention, they did not say staff left the unit because of staffing. Nursing leaders in this study also described the systemic effect of staffing difficulties. Inadequate staffing on the Medical-Surgical Units can adversely affect patient through-put and the movement of patients from the Emergence Department (ED), Post-anesthesia Care Unit (PACU), Intensive Care Units (ICU), and from step-down units. Low staffing on the Medical-Surgical Units inhibits the ability of other units to transfer patients to these units creating a bottleneck. For instance, if a full ICU cannot move a patient out of its unit to a Medical-Surgical Unit, it cannot accept a patient from the PACU or the ED. This bottleneck results in the PACU or the ED holding this high acuity patient until an ICU bed becomes available. In describing the systemic effect of inadequate staffing on another unit, one nursing leader stated, "We have some of the best staffing in the hospital. We are very well staffed. But, one call out still puts us over the edge. Staffing on the floors, when I know that [the Medical-Surgical unit] is going into the evening shift with one nurse on the schedule, I panic. How busy are we going to be? How busy are we now? We're going to be holding the Med-Surg patients" (NL #8). Holding patients, or placing patients in units that do not normally

accept these types of patients, increases mortality risks (Chaflin et al., 2007; Richardson, 2006). Staff and nursing leader satisfaction tie into these elements. When staffing ratios and acuity rise above the normal levels and persist there, staff satisfaction decreases. It is at these times that the nursing leaders function as advocates for their staff in order to provide adequate coverage of the unit.

The nursing leaders described the challenge of balancing productivity and costs with quality. Anthony et al (2005) identified this fiscal skill as a key role for managers. In the study site, senior administrators hold nursing leaders accountable for controlling and monitoring these concepts. The next section offers a discussion on the culture of accountability and its influence on the system.

Culture of accountability.

Not only do senior administrators hold nursing leaders accountable for productivity targets, they also hold them accountable for staff turnover. Human Resources provides these numbers to the nursing leaders monthly and the nursing leaders receive annual evaluation on them. Although the annual performance plan separates voluntary versus involuntary turnover, it does not take into account the “positive” turnover. At least one nursing leader voiced dissatisfaction with this process. Her unit is a “training” ground, and she supports staff development in which the nurse transfers to a unit providing a higher level of care. She also stated that because she created some positive turnover, some of the nurses that initially left because of staff issues have since returned to the unit. These factors are not considered when calculating the turnover rates upon which the nursing leaders are evaluated.

Another element of accountability pertains to core measures. Core measures came about through the efforts of the Centers for Medicare & Medicaid Services and the Joint Commission to achieve common national hospital performance measures on identified disease processes (jointcommission.org, 2008). Nursing units and the organization as a whole must meet certain benchmarks. The ability to meet these benchmarks ties back into delivery of patient care. High staffing ratios affect the quality of patient care that ultimately reflects in these quality outcome measures. Balancing these competing demands challenges nursing leaders.

In attempting to balance administrative and staff expectations, the nursing leaders reported what Sullivan et al (2003) termed "middle management syndrome." The nursing leaders represent both administration and the staff and frequently function as a liaison between the two. Although not specifically mentioned in this study, this situation requires strong negotiation skills in addition to strong communication skills. In serving as an advocate for the staff, the nursing leader draws on these competencies. When handled competently, the needs of both parties are considered and addressed.

Administrative support.

In this concept, the nursing leaders described the degree to which they felt supported by senior administrators to perform their roles/responsibilities. This concept ties into the previous one, culture of accountability. As leaders are held accountable, how does administration support them in meeting these expectations? Administrative support comes in many ways. Just as the nursing staff need accessibility and visibility of the nursing leaders, the nursing leaders need these elements from senior administrators. Only

when this situation occurs can the nursing leaders communicate to the staff the vision, mission, and goals of the organization. Upenieks (2003) credits organizational structures that support and empower nursing leaders with enhancing staff retention. The study participants voiced feeling empowered and, therefore, described situations in which they in turn empowered the staff.

In addition to empowering nursing leaders, senior administrators have a responsibility to create a culture and environment in which the nursing leaders can growth and develop in their leadership roles. The study site accomplished this element through the professional development classes offered through Human Resources and the Organizational Development department. The organization also offers tuition reimbursement for continuing education and academic courses. The study participants overwhelming felt that they had the support of senior administrators. While they relied on the senior administrators to give them a "global" perspective, they relied on each other for the day-to-day operational needs. In creating a tight network of peer support, the nursing leaders voiced strong job satisfaction.

Despite the many challenges these nursing leaders indicated facing, they all voiced a feeling of satisfaction with their role and with the organization overall. The employee engagement survey for the nursing leaders substantiated this fact. Reasons for satisfaction corroborated with those found by Sullivan et al. (2003). Elements of similarity include "autonomy," interaction with patients and families, staff development, peer support, and feeling the nursing leadership role plays an important part in organizational success (e.g. "makes a difference").

In Sherman et al's study (2007), the experienced leaders expressed a higher level of job satisfaction than new nursing leaders. No differences surfaced along experience lines for this study. Gould et al. (2001) conducted a study among nursing leaders in the United Kingdom. Among these nursing leaders, those reporting feeling inadequately prepared for their position voiced lower levels of personal job satisfaction. Again, no such differences surfaced in this study although six nursing leaders voiced feeling uncomfortable with their level of leadership skills when first assuming the role. The findings suggest that previous leadership experience and working in the unit prior to becoming the leader increases comfort with skill level. Of note is the fact that the study site encourages leaders to send shift managers and charge nurses to the leadership classes offered through the Organizational Development (OD) department. All the study participants reported attending a variety classes through OD, either prior to assuming the position or afterwards.

Administrative follow through and follow up.

This last concept in this theme pertains to the degree to which nursing leaders felt that senior administrators adequately follow through on promises and follow-up on issues. This concept arose as a consistent dissatisfier for staff in the employee engagement survey. As such, it jeopardizes senior administrators' credibility. It creates an environment of distrust within the organization and leaves the nursing leaders doing "damage control" with the frustrated staff. Nursing leaders expressed several ways of addressing this situation. Several nursing leaders met with senior administrators and reviewed the results of the employee engagement survey and explained to the

administrators how their unfulfilled promises impacted the staff as reflected in the survey. Several invited the administrators to attend staff meetings in order to facilitate the follow-up. Despite these actions, if administrators do not monitor their own behaviors and communication, these issues will arise again in the next employee engagement survey.

Conclusion.

This section described the systemic effect of the internal environment on the nursing leaders and how these concepts influence the decisions nursing leaders make as well as the behaviors nursing leaders exhibit. For the elements beyond the nursing leaders' control, effectively communicating to staff what can be control aids in keeping staff informed of larger organizational issues. The culture of accountability starts with senior administrators and filters down to the staff. Meeting standardized benchmarks for quality indicators ultimately improves patient care and outcomes. By creating a support and empowering environment for the nursing leaders, senior administrators model behaviors associated with increased job satisfaction and retention.

This section described the interpretation of the findings from a systemic perspective. Just as nursing leaders do not operate in a vacuum, organizations also operate within a larger system. Since the start of the data collection for the study, this larger, external environment has undergone dramatic changes that have a strong potential to influence patients, bedside nurses, nursing leaders, and senior administrators. The following section highlights these external environmental changes with future implications.

Systemic Changes Occurring During the Course of the Study

During the time of the study, the United States experienced a time of significant economic and political change. The stock market dropped precipitously. Congress offered financial corporations large "bail outs." Locally, a large corporation with businesses nationally filed for bankruptcy, and approximately 35,000 people lost their jobs.

In addition to the economic turmoil, a change in political structure occurred with the change from a Republican president to a Democratic president. With this change, two of the three branches of the government came under Democratic National Party (DNP) political influence. The DNP promises wide-spread healthcare reform. Anticipated cuts to governmental Medicare and Medicaid spending prompted healthcare organizations to review their payer mix and project further decreases in revenue from government sources.

Faced with decreased revenue, administrators within the study site, examined where cuts needed to be made in order to remain competitive and solvent. During the time of the study, the study site underwent a series of lay-offs and position cuts. Registered nurses (RNs) laid-off worked in outpatient areas, such as cardiac rehabilitation and patient education. Some RNs employed in mid-level leadership positions, such as assistant directors, were offered positions in direct patient care or other open positions. Administration chose to eliminate some open positions within the hospital rather laying off individuals already in a position. For instance, the open nursing director position on one floor with two distinct areas was divided and the responsibilities for these areas given to two nursing leaders currently overseeing other nursing units.

This capricious climate resulted in a change in the overall general ambiance of nursing staff within the organization. In the past, a common perception existed in which nurses felt, and even stated, “There’s a nursing shortage...I will always have a job.” The economic downturn, locally, within the United States, and globally, has altered the perception of many nurses. In the focus group, some nursing leaders reported decreased likelihood of staff nurses to change positions for fear of being the “last in, first out” should another round of lay-offs occur. In the focus group, one nursing leader voiced her intent to “stay right where I am. I have no desire to move into a higher [leadership] position that might be cut.”

What overall impact might these societal changes have on nursing and the nursing shortage? Faced with significantly decreased retirement portfolios, will nurses nearing retirement choose to remain in their current positions in hope of a market recovery? Will nurses be less likely to search out other job opportunities? The nursing leaders gave “family circumstances” as the predominant reason staff leave their units. Given widespread lay-offs throughout the U.S., there exists the potential for movement to occur as nurses’ family circumstances change. As families move from these geographic areas in search of jobs elsewhere, some healthcare organizations may suffer increased nursing shortages, whereas other areas may have fewer nursing positions available as nurses choose to stay or further position cuts occur.

The aging U.S population lends itself to increased demand for healthcare services in the future. In addition, with more people unemployed, more individuals and families

will qualify for government assisted healthcare services. The question will be whether healthcare organizations can continue to remain solvent and provide quality healthcare.

Implications

The findings of this study are both timely and relevant for healthcare administrators, Human Resource administrators, Organizational Development instructors, nursing leaders, and academic nursing institutions. Menix supports specifically training nursing leaders in stating, “without appropriate educational preparation nurse managers may not have the competencies to effectively manage accelerated change” (2000, as cited in Contino, 2004, p. 57). This study clearly illustrates the nursing leaders’ need for specialized and intentional training. The findings of this study highlight the specific skills frontline nursing leaders suggested to develop competency in key areas likely to influence staff retention. It is recommended that academic and institutional training programs integrate these concepts into their curriculum. Incorporation of systems thinking into the training will help nursing leaders to link these competencies to retention and patient outcomes.

Unique to this study is the frequency with which the nursing leaders spoke of “positive” turnover as an intentional strategy for creating the right team on their unit. Previous studies have either not explored or acknowledged this aspect of retention and turnover. Multiple times the nursing leaders spoke of creating turnover in order to improve, either the quality of care delivered on the unit, or to create a more cohesive team. Retention studies stress the importance of building the “right” team and creating a

supportive environment among the staff (Force, 2005). The findings of this study suggest that positive turnover serves as a strategy for creating the right team.

The findings of this study will also aid Human Resource Departments in writing job descriptions that delineate specific competencies and related behavioral statements for the roles and responsibilities of nursing leaders. This study identified specific behaviors and attitudes that can be integrated into the job description and into an annual performance appraisal. These documents will also assist senior administrators when hiring for the nursing leaders position. Looking for people with these skills and attitudes increases the chance of hiring a person who will have the skills and attitudes to target retention.

Lastly, the findings of this study will be of interest to current nursing leaders who want to hone their leadership skills and target staff satisfaction and retention. Knowing what behaviors and attitudes influence staff retention is the first step to becoming a "chief retention officer" (Manion, 2004).

Delimitations and Recommendations for Future Studies

Although the study findings are compelling, several limitations exist. This study explored frontline nursing leaders' perceptions of behaviors and skills that they believe influence staff retention. Generalization of these perceptions to other levels of leadership may be limited, although the flattening of organizational structures has created similarities in competencies for frontline nursing leaders and senior nursing leaders.

A second limitation pertains to the narrowness of the focus. This study concentrated on the competencies, behaviors, and attitudes of frontline nursing leaders

that they believe aid in retaining staff. While helpful for training and education, the study does not provide sufficient data to develop an inclusive, comprehensive nursing leadership curriculum. The AONE and AACN's program, *Essentials of Nurse Manager Orientation,* and the work of Sherman et al (2007) provide an overall comprehensive list of competencies for frontline nursing leaders.

A third limitation relates to the participants and the site for the study. The participants were from a single community acute healthcare organization in central Virginia. The competencies, behaviors, and attitudes identified by these community hospital frontline nursing leaders may vary from that of a frontline nursing leader employed in an academic or long-term care facility. Generalization to other parts of the U.S. and abroad may be limited.

A final limitation pertains to the fact that the study only explored the perceptions of frontline nursing leaders. The study did not assess the perceptions of nursing staff, Human Resource personnel, or senior administrators. This study sought to generate a theory or model of frontline nursing leadership behaviors and attitudes related to staff retention within a specific context and construct. The rigor with which the researcher conducted this study lends the findings to the potential for generalization. Generalization will need to be done by individual readers by assessing similarities with their situations.

Future researchers might consider exploring how these behaviors align with staff perceptions, especially in the area of "positive" turnover. This study yielded data on frontline nursing leaders' espoused theory. Future studies should test their theories-in-use, what behaviors and attitudes are actually observed. These behaviors and attitudes

should be validated by those persons in direct contact with the frontline nursing leader. Future studies can expound on this study's findings and explore the possible correlation between these behaviors, staff retention, and quality outcome indicators. Do nursing leaders who exhibit these behaviors have more satisfied patients, families, and physicians?

Of interest given the changing demographics of the nursing population regarding education and entry into the profession is how will having more ADN prepared nurses in the workforce affect turnover rates? Does degree preparation have more of an influence on turnover than age of the nurse? Studies indicate that younger nurses crave a variety of experiences and account for higher turnover rates (Strachota et al, 2003). Given the current economic state of the United States, does this finding still hold true?

Conclusion

At a time of an uncertain economic future with decreased reimbursements looming, focusing efforts on retaining staff becomes paramount to addressing the staffing shortage. Savvy consumers have the capacity to investigate readily available quality outcome indicators and choose a healthcare facility with a proven record. Studies show retaining experienced nurses increases quality of care and patient safety.

Findings of this study concur with findings of previous studies on general nursing leadership competencies. Unique to this study was exploration into which of these competencies the nursing leaders perceived as influencing staff retention. The below average turnover rate for the study site lends some credence to the effectiveness of the competencies these nursing leaders espoused. Application of these behaviors and

attitudes in a different clinical setting may have varied results; however, the evidence tends to support the effectiveness of these competencies.

This study emphasized the importance of retaining staff as a key component of the nursing leadership role and identified behaviors and attitudes likely to influence staff retention. Human Resources can use this information for the development of job descriptions and performance evaluations. Understanding the relationship of nursing leaders and staff retention, and the behaviors and attitudes influencing staff retention, can help healthcare administrators in the hiring process. The use of behavioral interviewing may elicit a potential candidate's competencies and attributes related to staff retention as identified in this study. Organizations with a culture of accountability annually evaluate the nursing leader's progress to meeting set benchmarks and provide opportunities for leadership development. Incorporation of the competencies, behaviors, and attitudes identified in this study into leadership development and training programs has the potential to strengthen the nursing leader's skills in the area of staff retention.

Snow (2001) asserts, "Nursing lags behind other industries in teaching and supporting research-based leadership theory that is linked to performance" (p. 440). There exists the need to incorporate evidence-based research in the development of healthcare leaders (Vance & Larson, 2002). Evidence generated from this qualitative research can guide development of leadership development programs within healthcare and academic institutions. The model generated from the data in the study using grounded theory illustrates the interrelatedness of the variables influencing nursing leaders and staff retention. The focus group validated the model. The next step in theory

development is theory testing to determine if the model works in a variety of environments and holds over time.

While this study does not definitively answer the question, “What level of education should a nursing leader have?” it does contribute to the body of knowledge supporting the benefits of BSN and MSN programs. For nurses with diploma or ADN degrees, organizations considering hiring them into leadership positions must assess their experience and skill mix and what organizational support exists to assist them. All nursing leaders need appropriate orientation, training, and mentoring when coming into the role. Chief Nursing Officers must take an active role in the on-boarding process for new nursing leaders. Visibility and accessibility prove vital to the success and satisfaction of nursing leaders. Also critical to the on-boarding process is the development of peer networks. These networks provide the new leaders with the day-to-day support needed to learn the role requirements and provide a much-needed social support system.

Many of the variables and concepts identified in this study can be monitored and controlled by the nursing leader and organization. Organizations creating a culture of accountability hold nursing leaders responsible for meeting benchmarks for these measurements, such as turnover rates and quality indicators. Retaining experienced staff, and encouraging sub-optimal performing nurses to leave, builds a strong nursing team, and should result in improved quality of patient care and outcomes.

Although the nursing shortage remains a multifaceted problem, focusing on staff retention has significant benefits for the healthcare organization in terms of increased patient care quality and decreased financial expenditures for hiring and training new

employees. Given the current economic state of the United States, decreasing expenditures in the face of decreasing reimbursement is not only prudent, it is essential to the solvency of healthcare organizations.

Literature Cited

Literature Cited

American Association of Colleges of Nursing (AACN). (2007). *Annual state of the school report.* Retrieved February 20, 2007, from http://www.aacn.nche.edu/Media/pdf/AnnualReport07.pdf

American Hospital Association. (2001). The hospital workforce shortage: Immediate and future. [Electronic Version]. *Trend Watch, 3*(2), 1-8.

American Nurses Credentialing Center (ANCC). (2008). *Magnet Recognition Program: Summary of key changes.* Retrieved February 13, 2009, at http://www.nursecredentialing.org/Documents/Magnet/MagnetManualKeyChanges.aspx

American Organization of Nurse Executives. (AONE). (2004). *Nurse Manager Inventory Tool*. Retrieved December 27, 2007, from http://www.aone.org/aone/resource/NMLC/InventoryAssessment030807.pdf

**American Organization of Nurse Executives. (2005). *Nursing Executive Competencies.* Retrieved October 29, 2007, from: http://www.aone.org/aone/pdf/February%20Nurse%20Leader--final%20draft--for%20web.pdf

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. [Electronic version]. *Qualitative Health Research, 6*(3), 379-393.

*Anthony, M.K., Standing, T.S., Glick, J., Duffy, M., Paschall, F., Sauer, M.R., Sweeney, D., Modic, M.B., & Dumpe, M.L. (2005). Leadership and nurse retention. [Electronic version]. *Journal of Nursing Administration, 35*(3), 146-155.

*Avolio, B.J. & Bass, B.M. (1998). You can drag a horse to water but you can't make it drink unless it's thirsty. [Electronic]. *The Journal of Leadership Studies, 4*(1), 393-399.

*Barling, J., Slater, F., & Kelloway, E.K. (2000). Transformational leadership and emotional intelligence: an exploratory study. [Electronic version]. *Leadership & Organizational Development Journal*, *21*(3), 157-161.

Barker, A.M., Sullivan, D. T., & Emery, M.J. (2006). *Leadership competencies for clinical managers. The renaissance of transformational leadership.* Boston: Jones and Bartlett Publishers

Bennis, W. (1989). *On becoming a leader.* Reading, Mass.: Addison-Wesley.

Bogdan, R.C. & Biklen, S.K. (2007). *Qualitative research in education* (5th ed.). Boston: Pearson.

*Bondas, T. (2006). Paths to nursing leadership. [Electronic version]. *Journal of Nursing Management, 14*, 332-339.

*Brewer, C.S., Zayas, L.E., Kahn, L.S., & Sienkiewicz, M.J. (2006). Nursing recruitment and retention in New York state: a qualitative workforce needs assessment. [Electronic version]. *Policy, Politics, & Nursing Practice, 7*(1), 54-63.

Bruce, C. D. (2007). Questions arising about emergence, data collection, and its interaction with analysis in a grounded theory study. *International Journal of Qualitative Methods, 6*(1), Article 4. Retrieved March 23, 2008, from http://www.ualberta.ca/~iiqm/backissues/6_1/bruce.pdf

Buckingham, M. & Coffman, C. (1999). *First, break all the rules.* New York: Simon & Schuster.

Burns, J.M. (1978). *Leadership.* New York: Harper & Row.

*Byers, J.F. (2000). Knowledge, skills and attributes needed for nurse and nonnurse executives. [Electronic version]. *Journal of Nursing Administration, 30*(7/8), 354-356.

*Byers, J.F. (2001). Voices from the field: health care leadership, challenges, and future vision. *Nursing Administration Quarterly*, 2001 Summer; *25* (4): 87-90. Retrieved January 31, 2008, from CINAHL database.

*Carroll, T. (2005). Leadership skills and attributes of women and nurse executives. [Electronic version]. *Nursing Administration, 29*(2), 146-153.

Chaflin, D.B.**,** Trzeciak, S., Likourezos, A., Baumann, B., & Dellinger R.P. (2007). "Impact of delayed transfer of critically ill patients from the emergency department to the intensive care unit." *Critical Care Medicine, 35*(6), 1477-1483.

Charmaz, Kathy (2000). Grounded theory: Objectivist and constructivist methods. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of qualitative research*, 2nd edition (pp. 509-535). Thousand Oaks, Ca.: Sage.

Conger, J.A. & Ready, D.A. (2004). Rethinking leadership competencies. [Electronic version]. *Leader to leader,* Spring, 41-47.

**Contino, D.S. (2004). Leadership competencies: Knowledge, skills and aptitudes nurses need to lead organizations effectively. [Electronic version]. *Critical Care Nurse, 24*(3), 52-64.

Corbin, J. & Strauss, A. (2007). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.

*Corning, S.P. (2002). Profiling and developing nursing leaders. [Electronic version]. *Journal of Nursing Administration, 32*(7/8), 373-375.

Creswell, J.W., Hanson, W.E., Clark Plano, V.L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. [Electronic Version]. *The Counseling Psychologist, 35*(2), 236-264.

Department of Health Professionals (DPH), Commonwealth of Virginia, Board of Nursing. (2008). *Report of Statistics*, July 1, 2007-June 30, 2008.

Denzin, N. & Lincoln, Y.S. (eds). (2005). *The Sage handbook of qualitative research.* Thousand Oaks, CA: Sage.

Duffield, C. & Franks, H. (2001). The role of preparation of first-line managers in Australia: Where we are going and how do we plan to get there? [Electronic version]. *Journal of Nursing Management, 9*, 87-91.

*Dunham-Taylor, J. & Klafebu, K. (1995). Identifying the best in nurse executive leadership. Part I, questionnaire results. [Electronic version]. *Journal of Nursing Administration, 25*(6), 68-70.

Ellenbecker, C.H., Samia, L., Cushman, M.J., & Porell, F.W. (2007). Employee retention strategies and their effects on nurses' job satisfaction and intent to stay. [Electronic version]. *Home Health Care Services Quarterly, 26*(1), 43-58.

Emmerling, R.J. & Goleman, D. (2003). *Emotional Intelligence: Issues and Common Misunderstandings*. White paper presented at the consortium for Research on Emotional Intelligence in Organizations, October 2003. Retrieved November 4, 2007, from www.eiconsortium.org

Flick, U. (2007a). *Designing qualitative research* (Book 1 of *The SAGE Qualitative Research Kit*). London: Sage.

Flick, U. (2007b). *Managing quality in qualitative research* (Book 8 of *The SAGE Qualitative Research Kit*). London: Sage.

*Force, M. (2005). The relationship between effective nurse managers and nursing retention. [Electronic version]. *Journal of Nursing Administration, 35*(7/8), 336-341.

French, W.L. & Bell, C.H. (1995). *Organizational development,* 5th Ed. Englewood Cliffs, NJ: Prentice Hall.

Gall, M.D., Gall, J.P., Borg, W.R. (2007). *Educational research* (8th ed.). Boston: Pearson.

Gardner, L. & Stough, C. (2002). Examining the relationship between leadership and emotional intelligence in senior level managers. [Electronic version]. *Leadership & Organizational Development Journal, 23*(1/2), 68-78.

Gibbs, G.R. (2007). *Analyzing qualitative data* (Book 6 of *The SAGE Qualitative Research Kit*). London: Sage.

Glaser, B.G. (2002) Constructivist grounded theory? *Forum: Qualitative Social Research, 3*(3). Available at http://www.Qualitative-Research.net/Fqs/Fqs-Eng.htm, Accessed on March 21, 2008.

Glauser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine

Glesine, C. (2006). *Becoming Qualitative researchers. An introduction* (3rd ed.). Boston: Pearson.

*Gould, D., Kelly, D., Goldstone, L., & Maidwell, A. (2001). The changing training needs of clinical nurse managers: exploring issues for continuing professional development. [Electronic version]. *Journal of Advanced Nursing, 34*(1), 7-17.

Government Accountability Office (GAO). (2007). *Nursing workforce: HHS needs methodology to identify facilities with a critical shortage of nurses.* Washington, D.C. Retrieved March 1, 2008, from http://www.gao.gov/new.items/d07492r.pdf

Greenberg, J. & Baron, R.A. (2003). *Behavior in organizations.* Upper Saddle River, NJ: Prentice Hall.

Harry, B. Sturges, K.M., & Klinger, J.K. Mapping the process: an exemplar of process and challenge in grounded theory analysis. [Electronic version]. *Educational Researcher, 34*(2), 3-13.

Health Resources and Services Administration (HRSA). U.S. Department of Health and Human Services. 2004 March). *Preliminary findings 2004 National sample survey of registered nurses.* Washington, DC. [On-line]. Available: http://bhpr.hrsa.gov/healthworkforce/reports/rnpopulation/preliminaryfindings.htm

Heller, B.R., Oros, M.T., & Durney-Crowley, J. (2000). The future of nursing education: 10 trends to watch. *Nursing and Health Care Perspectives, 21*(1), 9-13.

Hemmila, D. (2002). Male Call. *NurseWeek,* October 22, 2002. Retrieved March 17, 2008 at http://www.nurseweek.com/news/features/02-10/malecall.asp

**Herrin, D. & Spears, P. (2007). Using nurse leader development to improve nurse retention and patient outcomes. [Electronic version]. *Nursing Administration Quarterly, 31*(3), 231-243.

Joint Commission Accreditation of Healthcare Organizations (JCAHO). (2007). *2008 National patient safety goals.* Retrieved November 13, 2007, from http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/08_npsg_facts.htm

**Jooste, K. (2004). Leadership: a new perspective. [Electronic version]. *Journal of Nursing Management,* 12, 217-223.

Kak, N., Burkhalter, B. & Cooper, M. (2001). Measuring the competence of healthcare providers. *Operations Research Issue Paper, 2*(1). Bethesda, MD: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance (QA) Project.

Kanter, R.M. (1993). *Men and women of the corporation* (2nd ed.). New York: Basic Books.

Kelle, Udo (2005, May). "Emergence" vs. "Forcing" of Empirical Data? A Crucial Problem of "Grounded Theory" Reconsidered [52 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* [On-line Journal], *6*(2), Art. 27. Retrieved March 28, 2008, from http://www.qualitative-research.net/fqs-texte/2-05/05-2-27-e.htm

Kerfoot, K. (2000). The leader as a retention specialist. [Electronic version]. *Nursing Economics, 18*(4), 216-218.

Kerfoot, K. (2007). Bossing or serving: How leaders execute effectively. [Electronic version]. *Nursing Economics, 25*(3), 178, 188.

Kimball, B. & O'Neil, E. (2002). *Health care's human crisis: The American nursing shortage.* Robert Wood Johnson Foundation. Retrieved July 14, 2004, from http://www.rwjf.org

Kleinman, C. S. (2003). Leadership roles, competencies, and education. [Electronic version]. *Journal of Nursing Administration, 33*(9), 451-455.

Kouzes, J.M. & Posner, B. Z. (1995). *The leadership challenge.* San Francisco: Jossey-Bass Publishers.

Kouzes, J.M. & Posner, B. Z. (2007). *The leadership challenge.* San Francisco: Jossey-Bass Publishers.

Krejci, J.W. (1997). Impact of leadership development on competencies. [Electronic version]. *Nursing Economics, 15*(5), 235-241.

Krueger, R.A. & Casey, M.A. (2000). *Focus Groups: A practical guide for applied research,* 3rd Ed. Thousand Oaks: Sage Publications

Kvale, S. (2007). *Doing Interviews.* Los Angeles: Sage.

Larkin, M. (2007). Shortage strategies: Retaining the experienced nurse. [Electronic version]. *Journal of Nursing Administration,37*(4), 162-163.

Laschinger, H., Purdy, N., & Almost, J. (2007). The impact of leader-member exchange quality, empowerment, and core self-evaluation on nurse manager's job satisfaction. [Electronic version]. *Journal of Nursing Administration, 37*(5), 221-229.

Larkin, M. (2007). Shortage strategies: Retaining the experienced nurse. [Electronic version]. *Journal of Nursing Administration, 37*(4), 162-163.

Leveck, M.L. & Jones, C.B. (1996). The nursing practice environment, staff retention, and quality of care. [Electronic version]. *Research in Nursing & Health*, 19, 331-343.

Lindholm, M. & Uden, G. (2001). Nurse managers' management direction and role over time. *Nursing Administration Quarterly, 25*(4), 14-29.

Lynn, M.R. & Redman, R.W. (2005). Faces of the nursing shortage. [Electronic version]. *The Journal of Nursing Administration, 35*(4), 264-270.

Malone, B. (September 17, 2003). Experience of a lifetime: older nurses offer maturity and expertise, so the NHS can't afford to lose them. *Nursing Standard,* 18 (1), 24. Retrieved via InfoTrac OneFile. Thomas Gale. May 27, 2006

Manion, J. (2004). Nurture a culture of retention. [Electronic version]. *Nursing Management, 35*(4), 28-35.

Manion, J. (2005). *From management to leadership. Practical strategies for health care leaders* (2nd ed.). San Francisco: Jossey-Bass.

Marquis, B.L. & Huston, C.J. (2009). *Leadership Roles and Management Functions in Nursing: Theory and Application.* Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins

*Mathena, K.A. (2002). Nursing manager leadership skills. *Nursing Administration, 32*(3), 136-142. Retrieved through Ovid, November 4, 2007.

Marshall, C. & Rossman, G.B. (2006). *Designing qualitative research* (4th ed.). Thousand Oaks: Sage.

McCaslin, M.L. & Scott, K.W. (2003). The five-question method for framing a qualitative research study. [Electronic version]. *The Qualitative Report, 8*(3), 447-461.

McMillan, J.H. & Schumacher, S. (2006). *Research in education* (6th ed.). Boston: Pearson.

*McNeese-Smith, D.K. (1997). The influence of manager behavior on nurses' job satisfaction, productivity, and commitment. [Electronic version]. *The Journal of Nursing Administration, 27*(9), 47-55.

*McVicar, A. (2003). Workplace stress in nursing: a literature review. [Electronic version]. *Journal of Advanced Nursing, 44*(6), 633-642.

NAS. (2005). *The nursing shortage.* [On-line]. Retrieved May 29, 2006, from www.nasrecruitment.com/microsites/Healthcare/articles/featureH5a.html

Neergaard, H. & Ulhoi, J.P. (2007). *Handbook of qualitative research methods in entrepreneurship.* Retrieved March 21, 2008, from http://www.netlibrary.com.proxy.library.vcu.edu/Reader/

Nelson, M. (May 31, 2002). "Education for Professional Nursing Practice: Looking Backward Into the Future". *Online Journal of Issues in Nursing*,7(3), Manuscript 3. Retrieved February 3, 2009. Available: www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume72002/No2May2002/EducationforProfessionalNursingPractice.aspx

Orb, A. Eisenhauer, L. & Wynaden, D. (2001). Ethics in qualitative research. [Electronic version]. *Journal of Nursing Scholarship*, First quarter, 93-96.

Peshkin, A. (2000). The nature of interpretation of qualitative research. *Educational Research, 29*(9), 5-9.

Porter-O'Grady, T. (2003). A different age for leadership, Part 2. New rules, new roles. . [Electronic version]. *Journal of Nursing Administration, 33*(3), 173-178.

Richardson, D.B. (2006). "Increase in patient mortality at 10 days associated with emergency department overcrowding." *Medical Journal of Australia, 184*(5), 213-216.

Robert Wood Johnson Foundation (RWJF). (2006). *Wisdom at work: The importance of the older and experienced nurse in the workplace.* [On-line]. Retrieved February 20, 2008. Available: www.rwjf.org.

Robrecht, L.C. (1995). Grounded theory: Evolving Methods. [Electronic version]. *Qualitative Health Researcher, 5*(2), 169-177.

*Scoble, K.B. & Russell, G. (2003). Vision 2020, Part I. [Electronic version]. *Journal of Nursing Administration, 33*(6), 324-330.

*Sellegren, S., Ekvall, G., & Tomson, G. (2006). Leadership styles in nursing management: preferred and perceived. [Electronic version]. *Journal of Nursing Management*, 14, 348-355.

Senge, P. M. (1990). *The fifth discipline.* New York: Currency Doubleday

*Sherman, R.O., & Bishop, M. (2007). Development of a leadership competency model. [Electronic version]. *Journal of Nursing Administration, 37*(2), 85-94.

Shirey, M.R. (2007). Competencies and tips for effective leadership. [Electronic version]. *Journal of Nursing Administration, 37*(4), 167-170.

**Snow, J. (2001). Looking beyond nursing for clues to effective leadership. [Electronic version]. *Journal of Nursing Administration,* 31(9), 440-443.

**Sofarelli, D. & Brown, D. (1998). The need for nursing leadership in uncertain times. [Electronic version]. *Journal of Nursing Management,* 6, 201-207.

Strachota, E., Normandin, P., O'Brien, N., Clary, & M., Krukow, B. (2003). Reasons registered nurses leave or change employment status. [Electronic version]. *Journal of Nursing Administration, 33*(2), 113-117.

*Sullivan, J., Bretschmeider, J., & McCausland, M. (2003). Designing a leadership development program for nurse managers. [Electronic version]. *Journal of Nursing Administration, 33*(10), 544-549.

*Upenieks, V. (2002). What constitutes successful nurse leadership? [Electronic version]. *Journal of Nursing Administration, 32*(12), 622-632.

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2004). *The registered nurse population: Findings from the 2004 national sample survey of registered nurses.* Retrieved February 3, 2009, from http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/

*Vance, C. & Larson, E. (2002). Leadership research: Research in business and health care. [Electronic version]. *Journal of Nursing Scholarship,* Second Quarter, 165-171.

Wong, C.A. & Cummings, G.G. (2007). The relationship between nursing leadership and patient outcomes: a systematic review. [Electronic version]. *Journal of Nursing Management, 15,* 508-521.

Zurmehly, J. (2008). The relationship of educational preparation, autonomy, and critical thinking to nursing job satisfaction. [Electronic version]. *The Journal of Continuing Education in Nursing, 39*(10), 453-460.

* References marked with a single asterisk indicate studies included in the systematic literature review described in Table 2 (p.19).

** References marked with a single asterisk indicate studies included in the systematic literature review. References marked with two asterisks indicate additional resources used to compile data in Tables 3 and 4 (p. 20-210)

Appendices

Appendix A

[Date]

Dear Colleague,

I have offered to assist Beth Torres, a PhD candidate from Virginia Commonwealth University, with her dissertation that focuses on frontline nursing leadership and staff retention. Specifically, her study will explore the competencies, behaviors, and attitudes of unit directors that influence staff retention. As you know, staff retention is a priority for [SITE]. The results of her study can help us to learn best practices within our institution toward this goal. Beth will be conducting one-on-one interviews with unit directors over the next couple of months. She will also conduct one or two focus groups after the interviews are completed. Each interview and focus group will last approximately one hour. Interviews and focus groups will be conducted at [SITE].

While your participation in the study is voluntary, I encourage you to participate. The more participants we have in the study, the more the data will reflect an accurate picture of [SITE] and provide us with valuable information on retaining staff.

Beth will present more information on her study at the Nurse Quality Council meeting on _____. She can answer questions at this time or feel free to contact her directly prior to our meeting.

Thank you for thoughtfully considering participating in this valuable and exciting research study.

Best,

Sharon

Appendix B

LETTER TO POTENTIAL PARTICIPANTS

Dear Colleague,

Healthcare institutions currently face a critical nursing shortage. Research in healthcare shows a strong relationship between job satisfaction and nursing retention. As a frontline nursing leader, you are in the unique position to describe your experiences of ways you have influenced staff retention. This study provides you with the opportunity to have your voice heard regarding the responsibilities and challenges nursing directors face in retaining staff. In addition to learning the behaviors and attitudes of frontline nursing leaders that influence staff retention, this study seeks to learn what nursing leaders perceive as the ideal educational and training requirements to learn the knowledge and skills necessary to competently function in this position.

Participation in this study is voluntary. If you choose to participate, you will be asked to complete a brief demographic survey and participate in an interview lasting approximately one hour. You will also have the opportunity to participate in a focus group to review the findings of this study if you so choose.

Risks are considered minimal in this study. All data will be kept confidential, and your identity will not be revealed or connected with the data. There are no risks to your employment status whether or not you choose to participate.

The data collected in this study will be used to create a model of frontline nursing leadership competencies and attitudes that influence staff retention. This model will facilitate the development of nursing leadership education and training curriculum. The information may also be helpful in the creation of job descriptions that incorporate what nursing directors do in their daily roles and responsibilities that promote staff retention. These job descriptions can then be used to facilitate the hiring process for this critical position.

Since your perceptions are important to this research, I hope you will participate. You will be contacted within the coming week to ascertain your willingness to participate in the study. If you choose to participate, a mutually agreeable date and time for the interview will be determined. Prior to the interview, you will receive a copy of this letter electronically along with a topical outline of the interview questions.

If you have additional questions or concerns about this study, feel free to e-mail or call me. Thank you in advance for your time and consideration.

Sincerely,
Beth Torres, M.Ed., BSN, RN, CCRN
Doctoral Student
Virginia Commonwealth University

Appendix C

Interview Guide

I am conducting this study to meet the requirements for my Ph.D through VCU. The purpose of this interview is to obtain information on experiences of nursing directors related to competencies, behaviors, and attitudes that you feel enhance staff retention. I would also like to obtain your opinion on education and training for related to your position as a nursing director. As a nursing unit director who has been in the position for at least 6 months, you are in the unique position to describe your experiences and the influence they have had on you.

Your answers will be confidential. Your identity will be protected in all written materials. Your answers will be combined with those of other nursing directors for the report. I do not foresee any risks involved in this study. Your participation is strictly voluntary, and you may decline to answer any question. You may also stop the interview at any point that you choose. I anticipate the interview lasting approximately 60 minutes.

Within the next week or two, you will receive a call from an outside individual not associated with [the study site] or VCU. This person will ask you a few questions about the interview process. If you decide that you would rather not participate in the study, this person will request that your data be omitted from the survey. This individual will not have access to your data other than your name and contact number. There is no consequence for withdrawing from the study. If you choose to remain in the study, you will be given the opportunity to review the transcript and make any changes or comments if you so desire. You may withdraw from the study at any point prior to November 30, 2008. After this time, your data will have been merged with other interviewees. I anticipate interviewing approximately 20 nursing directors.

What questions or concerns do you have before we begin? If you have no [further] questions, I would like to ask that you read and sign the written consent form. I would like to collect some demographic information from you first and then we will begin the interview. I will turn the tape recorder on when the actual interview begins. I will also be taking some notes during the interview in case the tape recorder fails.

Interview Questions

1. How do you think you, as the director of this unit, influence retention of staff?
    a. Describe the behaviors you believe nursing unit directors must exhibit that promote staff retention.
    b. What attitudes do you feel nursing leaders should have in order enhance staff retention?
    c. Which of these behaviors and attitudes do you feel you exhibit most frequently?
2. You recently received the results of your unit's employee satisfaction scores.
    d. Were there any surprises? Please elaborate, **or**, If so, how did the results surprise you?
    e. What factors do you believe influenced these results?
        i. Which of these factors do you feel are within your control?
        ii. What do you plan to do to maintain or alter these factors?
        iii. For those factors you feel are outside your control, how do you plan to address these issues with the staff?
    f. Are you satisfied with the results?
    g. What do you feel might change or influence future results?
3. What is your unit turnover rate?
    h. Have you seen a change in your turnover rate in the last 12 months [or since you assumed this position]?
    i. What do you feel accounts for this level of turnover?
    j. How do you think you, as the director of this unit, influence turnover?
4. If you could make one change to impact retention, what would you do?
5. Tell me about your training to prepare you for this position.
    k. What training/education have you received that has helped with regard to retaining staff?
    l. What do you think would help you learn or implement strategies for retaining staff?
6. What was your level of comfort in terms of your leadership/management skills and abilities related to staff retention when you transitioned into your current position?
    m. Tell me about your orientation to this position. How was staff retention or turnover addressed?

   n. What additional education or training would you have found beneficial?
7. If you were designing an educational training program for new nursing leaders, what elements related to staff retention would be important to include?
   o. Which ones do you feel are critical to staff retention?
   p. Please rank these elements in order of importance. Describe why you ranked them the way you did.
8. What level of education do you feel is necessary to be effective as a unit director? Why?

9. What else would you like to say about being a nursing director at [the study site] and your ability to influence staff retention?

Appendix D

Consent Form

TITLE: Frontline Nursing Leaders and Staff Retention in an Acute Care Community Hospital

VCU IRB NUMBER: HM11827
[SITE] IRB APPROVAL: September 26, 2008

INVESTIGATORS: William Bosher, Ed.D.
Beth Torres, M.Ed. (student researcher)

This consent form may contain words that you do not understand. Please ask the study staff to explain any words that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

PURPOSE OF THE STUDY
The purpose of this research study is to collect information on frontline nursing leadership behaviors that enhance retention of nursing staff, to add to the body of knowledge with the data and analysis from this study; and finally, to build a theoretical model, which facilitates the process of educating and hiring current and future nursing leaders.

DESCRIPTION OF THE STUDY
If you decide to participate in this research study, you will be asked to sign this consent form after you have had your questions answered. Participants in this study will be interviewed by Beth Torres. Interviews will last approximately one hour. You will also be asked to participate in a focus group at a later date to assist in validating the data collected and analyzed by the researcher. The focus group will consist of 5-10 participants and last no more than one hour. You may choose to participate in the interview and opt out of the focus group.

Approximately 20 individuals will be invited to participate in the study.

At the beginning of the interview session and in the informed consent process, the investigator will explain the purpose of the study and how the data will be collected, analyzed, and reported. You will have the opportunity to ask questions about the study prior to signing an informed consent form and commencement of the interview. Signed consent forms will be retained by the investigator and kept in a secured location. You will be provided a copy of the consent form.

An outside agent will contact you no later than two weeks from the date of your interview to ask a few questions about the interview process. You will have the option to request that your data be omitted from the study at this point if you so chose. If you choose to continue in the study, a copy of the audiotaped transcript will be sent to you by your requested method. You may waive the right to be contacted by this outside agent. Doing so implies voluntary participation in this study and the transcribed interview will automatically be sent to you for review.

Data will be collected using multiple methods. Demographic information will be manually recorded in a written survey format. The interviews and focus groups will be audiotaped to ensure accuracy of the information collected. In addition to audiotaping, the researcher will record notes manually in the case of a recording malfunction. You will have an opportunity to review the audiotaped interview transcripts for accuracy and make changes or additional comments for clarification. These transcripts will not contain any personal identifiers. You will have the option to receive an electronic copy or a hard copy of the transcript for authentication purposes.

Additionally, the researchers will obtain blank copies of job descriptions and performance appraisals (job evaluations) from Human Resources to compare to the data obtained from the nursing leaders. Staff turnover and job satisfaction data will also be obtained from Human Resources. The researcher will additionally work with the facility's Organizational Development Department to determine what types of educational programs are currently available to staff.

RISKS AND DISCOMFORT:
There is no greater risk than a minimal risk to participants in the study. You may choose to not answer any questions with which you are uncomfortable and may stop the interview at any point.
You may also withdraw from the study at any point. There are no risks to your employment status whether or not you choose to participate or if you choose to withdraw from the study.

As with any research study, there may be unforeseeable risks. If any new information about the study becomes known that may cause you to change your mind about continuing in the study, you, will be told, and you will be given the opportunity to withdraw from or to

continue in the study. Beth Torres may withdraw you from the study at anytime, if the researchers decide to stop the study for administrative or other reasons.

INJURY
This study does not include a treatment or intervention. It is not anticipated that you will be injured as a result of participating in this study. If you believe that you have been injured as a result of participating in this study, please contact Beth Torres at pager number 804-759-7243, 24 hours per day. In the event of a research-related injury, necessary medical treatment will be provided at [SITE] to assist in your recovery from the injury. The costs for this treatment will be billed to your insurance or other third party payer. You will be billed for any services not covered by your insurance company or other third party payer. The researchers do not have a program set up to provide financial compensation to you in case of injury. By signing this informed consent form, you are not waiving any legal rights to which you would normally be entitled.

BENEFITS TO YOU AND OTHERS
Although you may not experience any direct benefit or compensation from participation in this study, the information gleaned from the participants in this study may help with the hiring and education of future nursing leaders. Additionally, the researchers may learn information about competencies that may influence nursing retention.

COSTS AND PAYMENT
There are no costs for participating in this study, other than the time it takes to complete the interview process and review the transcripts. Additional time will be required if you choose to participate in a focus group.

You will not receive additional payment as a result of participating in this study.

FUNDING
Beth Torres and [SITE] are not receiving funding to conduct this research.

CONFIDENTIALITY
Every effort will be made to protect your identity in this study. Data is being collected only for research purposes and will not be individually shared with others. Your data will be identified by an ID number and an alias name, and stored in password protected files. These materials will not have personal identifiers attached to them. The subjects' interviews will be audio recorded and all of the information will remain confidential. Audiotapes will be labeled with an ID number only. The researcher and a transcriber will listen to the tapes and transcribe all of the tapes. Once transcribed, the original tapes will be stored in a secure location. The tapes and transcripts will be kept approximately one year beyond the completion of the dissertation for purposes of verification and in the event there is a need to continue or expand the research. The tapes will then be destroyed. Access to audiotaped data will be limited to the study personnel.

The transcripts may be reviewed or copied by the research sponsor, Dr. Bosher, Virginia Commonwealth University Institutional Review Board, [SITE] Human Research Committee, the United States Department of Health and Human Services, and the United States Food and Drug Administration. When the results are presented in meetings or in publications, no identifiable personal information will be disclosed or attached to the data.

No personal medical data will be collected as part of this study.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Participation in this study is voluntary. If you decide to participate, you may skip any question you choose not to answer. You may also stop the interview at any time without repercussions. You have the right to withdraw from the study at any time, either during the interview or afterwards. You will be contacted by an outside person within two weeks of the interview to ascertain your perceptions of the interview process. If you choose to continue in the study, a copy of the interview transcript will be sent to you for review. It is requested that you read and alter or approve the transcript within 10 days of receipt. If the researcher does not hear from you within 10 days, you will be contacted to determine if you need more time or if the transcript accurately reflects your perceptions.

If you decide to not participate in this research study, or if you decide to withdraw from this research study, you will not be penalized and you will not lose any benefits to which you are normally entitled to receive.

ALTERNATIVES

Participants may elect not to participate in this study without impacting employment.

QUESTIONS

If you have questions about participating in this study, you may contact:

William C. Bosher, Ed.D.
CCRN
Associate Professor
Wilder School
Virginia Commonwealth University
919 W. Franklin Street
Richmond, VA 23284

804.827.3290
Email: wcbosher@vcu.edu

Beth L. Torres, M.Ed., BSN, RN,

Student Researcher
School of Education
Virginia Commonwealth University
919 W. Franklin Street
Richmond, VA 23284

804.560.5905
Email:
Beth.Torres@hcahealthcare.com

If you have questions about your rights as a participant in this study, you may also contact:

Office of Research
Virginia Commonwealth University
800 East Leigh Street, Suite 113
P.O. Box 980568
Richmond, VA 23298
Telephone: 804.827.2157

You may also contact a VCU Medical Center Institutional Review Board or [SITE] Human Research Committee representative for general questions, concerns, or complaints about this research study. For VCU, please call the number listed above if you cannot reach the research team or wish to talk to someone else. Additional information about participation in research studies in available http://www.research.vcu.edu//irb/volunteers.htm. For the [SITE] Human Research Committee, call (804) XXX-XXXX.

CONSENT

I have been given the chance to read this consent and ask questions. I understand the information described in this consent form. My questions have been adequately answered. By signing this form, I consent to participation in this study. I understand that I will receive a copy of the consent form once I agree to participate.

Participant:_____ _____ _____
Signature Printed Name Date

Witness:_____ _____ _____
Signature Printed Name Date

Investigator: _____ _____ _____
Signature Printed Name Date

Do not write in this section
Date:_____
No. _____
Alias: _____

Appendix E

Demographic Information

1. How many years have you worked in leadership/management? _____
2. How long have you been in leadership/management at [SITE]? _____
3. How many units do you manage? _____
4. How many total FTE's do you oversee? _____
   Please indicate approximately how many employees you have in each of the categories below.
   a. _____ Assistant Director
   b. _____ Clinical Coordinators
   c. _____ RNs/LPNs
   d. _____ NT/NAs/Paramedics
   e. _____ Department assistants
   f. _____ Other (Please specify) _____
5. What is the turnover rate(s) for the unit(s) you oversee?
6. What is your highest educational level?
   a. _____ Masters (specify) _____
   b. _____ Bachelors (specify) _____
   c. _____ Associate Degree in Nursing
   d. _____ Diploma
7. What additional educational training have you completed related to leadership?

Thank you for taking the time to provide this information and participate in the study.
All information is confidential.

Do not write in this section	
Transcribed: _____	HC: _____
Coded: _____	Email: _____

Appendix F

Focus Group

Opening Statements

I am conducting this study to meet the requirements for my Ph.D through VCU. The purpose of this focus group is to present to you a summary of the information collected during the interviews on the experiences of nursing directors related to competencies, behaviors, and attitudes that they felt enhance staff retention. I would like the group to discuss whether the generalizations accurately reflect your experiences or those you have observed. Your individual experience may differ from the general perceptions of your peers. If so, feel free to indicate so. During the discussion, I might ask clarifying questions to make sure that I heard and understood you correctly. Please feel free to do so among yourselves as well.

Please maintain the respect and dignity of other group members during the focus group by allowing every one to have an opportunity to voice his/her opinion without constraint. I also request that you maintain group confidentiality by not discussing who participated in the focus group and attributing quotes to a specific person.

What questions can I answer for you prior to starting?

If there are no [further] questions, I will now start the audiotaping of this session.

[No specific questions will be used in this session other than to present the data and then ask, “How accurately does this information represent your experiences or what you have witnessed in other nursing directors at [SITE]?” Participants will be asked to elaborate on their statements.]

Appendix G

Data Coding System

Code 1: Behaviors
Definition: This code contains descriptions of behaviors the NDs indicate that they use to positively influencing staff retention.

Code 2: Attitudes
Definition: This code contains descriptions of attitudes the NDs indicate that they use to positively influencing staff retention.

Code 3: Employee Engagement Survey
Definition: This code contains statements the NDs made regarding employee engagement surveys

Code 4: Employee Engagement survey: Factors
Definition: This code describes factors the NDs believe are outside their control that influenced how the staff responded to the survey questions

Code 5: Influences on Future Employee Engagement Results
Definition : This code describes factors the ND feel will influence future employee engagement survey results.

Code 6: Turnover
Definition: This code describes the unit's turnover rate

Code 7: Reasons staff leave the unit
Definition: This code describes reasons that the ND give for why staff have left their unit.

Code 8: Ways the ND influences Turnover
Definition: This code describes ways in which the ND say they influence staff leaving the unit.

Code 9: Promoting change that influences retention
Definition: This code describes how the ND believe they can make a change that will influence staff retention

Code 10: Preparation for ND position
Definition: This code describes information the ND provided on how they prepared for the ND position, including information on the orientation process, formal classes, and informal learning.

Code 11: Level of comfort
Definition: This code includes data regarding how comfortable the ND felt when he/she first entered the ND position.

Code 12: Training new leaders
Definition: This code includes data regarding what training the ND felt a new ND would benefit from completing. It incorporates the ND suggestions for training content.

Code 13: Ideal Level of Education
Definition: This code describes the ND perceptions of the ideal level of education and training that should be required for this position.

Code 14: Biggest Challenge facing ND
Definition: In this code, the ND describe the biggest challenges they face in the ND position related to staff satisfaction and retention.

Code 15: Nursing staff/Unit
Definition: This code describes how the nursing directors describe or discuss factors about their staff/unit.

Code 16: Administrative support
Definition: This code describes instances in which the ND discuss administrative support

Code 17: Satisfaction with ND role
Definition: This code describes instances in which the ND describe level of satisfaction with their role

Code 18: Suggestions for staff retention
Definition: This code describes instances in which the ND offer suggestions for improving staff retention

Code 19: ND Job Description

Definition: This code describes instances in which the ND describe aspects of their job description and role expectations

Code 20: Mentors/Previous Influences on Leadership Style

Definition: This code includes instances in which the NDs describe people who have influenced their leadership style and they describe behaviors or attitudes they desire to emulate or to not model.

Appendix H

Summary of Data Units by Interview and Codes

	Codes																					Interview Length (min:sec)
Interview	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	TOTAL	
1	6	10	2	3	0	1	1	0	1	3	1	1	1	3	3	2	1	0	0	0	39	19:02
2	5	4	2	0	0	1	3	2	5	4	1	3	6	1	0	0	4	0	0	4	45	30:00
3	15	2	1	3	0	1	5	0	1	1	1	2	1	1	0	0	0	5	0	0	39	21:22
4	7	2	2	6	1	2	3	0	1	5	0	5	1	2	0	2	1	3	4	0	47	30:50
5	16	7	1	3	2	2	5	2	4	10	2	5	4	1	3	2	1	4	0	1	75	30:05
6	8	2	8	0	0	3	3	0	1	4	2	6	4	2	1	6	1	0	0	1	52	42:29
7	8	5	5	2	2	4	5	0	6	16	2	5	3	3	3	0	3	0	2	1	75	40:06
8	10	5	6	2	1	5	0	1	5	10	1	3	4	5	4	6	0	0	0	1	69	34:58
9	20	3	4	2	2	2	3	3	4	5	1	6	1	0	1	2	3	0	0	0	62	34:14
10	9	3	5	1	2	1	3	3	1	2	12	10	2	2	3	3	1	1	0	3	67	29:46
11	6	4	10	0	4	1	3	1	4	5	1	6	2	1	0	0	2	3	0	3	56	33:49
12	7	4	7	1	1	1	10	0	2	10	2	5	2	4	1	4	4	0	0	2	67	41:43
13	19	9	7	1	3	1	6	0	3	4	1	5	2	1	6	0	2	6	0	0	76	43:46
14	13	5	6	2	2	2	5	3	3	2	2	2	3	2	3	3	1	0	1	0	60	43:46
15	10	4	10	2	2	1	4	4	3	2	2	3	3	5	3	2	9	2	0	6	77	36:42
16	14	3	3	2	1	1	5	1	1	3	1	6	4	1	0	1	2	0	0	2	51	26:39
17	12	3	5	2	1	1	3	0	1	2	0	1	4	3	1	0	4	0	0	1	44	25:41
18	18	2	4	1	1	2	2	4	4	3	1	1	5	2	6	1	1	0	0	3	61	28:57
19	14	11	9	0	1	1	3	3	1	8	1	5	1	1	4	0	1	0	1	0	65	35:59
TOTAL	217	88	97	33	26	33	72	27	51	99	34	80	53	40	42	34	41	24	8	28	1127	629:09
AVE	11.4	4.6	5.1	5.1	1.6	1.7	3.8	1.4	2.7	5.2	1.8	4.2	2.8	2.1	2.2	1.8	2.2	1.3	0.4	1.5	59.3	33:15

Appendix I

VCU Memo

Virginia Commonwealth University

Office of Research Subjects Protection

BioTechnology Research Park
800 East Leigh Street, Suite 114
P.O. Box 980568
Richmond, Virginia 23298-0568
(804) 827-0868
Fax: (804) 827-1448

DATE: October 6, 2008

TO: William C. Bosher, PhD
Wilder School and School of Education
Box 842020

FROM: Elizabeth Ripley, MD, MS
Chairperson, VCU IRB Panel B
Box 980568

RE: **VCU IRB #: HM11827**
Title: Frontline Nursing Leaders and Staff Retention in an Acute Care Community Hospital

On October 3, 2008, the changes to your research study were ***approved*** in accordance with 110 (b) (2). This approval includes the following items reviewed by this Panel:

CONSENT/ASSENT (attached):

- Consent Form, received 10/2/08, version date 9/25/08 (approved by [redacted] IRB on 9/26/08), 5 pages

ADDITIONAL DOCUMENTS (attached):

- Recruitment Letter, received 10/2/08, version date 9/25/08 (approved by [redacted] IRB on 9/26/08)

As a reminder, the approval for this study expires on August 31, 2009. Federal Regulations/VCU Policy and Procedures require continuing review prior to continuation of approval past that date. Continuing Review report forms will be mailed to you prior to the scheduled review.

The Primary Reviewer assigned to your research study is Mrs. Emily Rossiter. If you have any questions, please contact Mrs. Rossiter at rri@infionline.net; or you may contact Jennifer Rice, IRB Coordinator, VCU Office of Research Subjects Protection, at jlrice@vcu.edu and 828-3992.

Appendix J

Organizational Development
Leadership Classes

2007 & 2008

Organizational Development offered the following Leadership classes to all employees in leadership positions within the organization. Classes marked with an * indicate classes the corporate office deemed mandatory.

*Intimidating and Disruptive Behavior
*Target Selection
*Generational Diversity
*Performance Management Plan
Essential Skills (mandatory for all new managers)
Action Planning
Benefits and Employment Law
Budget, Payroll, and Productivity
Coaching and Counseling
Communication
Conflict Resolution
First Line/First Time Supervisors
Gallop Training
Labor Relations
Lawson
Leading Staff Through Change
Mentor Role
Open Forum: variety of topics depending on persons attending
Personal Productivity
Process Improvement, Continual Readiness, & Core Measures
Recognizing Employees
Retention and Recruitment
Staff Educational Needs
Targeted Selection
Team Building
Work-Life Balance

Vita

Born and raised most of her life in the tri-cities of Richmond, Virginia, Beth Lindsey Torres graduated from Powhatan High School in 1980. She attended Old Dominion University in Norfolk, Virginia, her freshman year before moving back to Richmond to attend Virginia Commonwealth University (VCU). She earned her Bachelor of Science in Nursing in 1984 from VCU Medical College of Virginia. Upon graduation, she began working for HCA at Chippenham Hospital on a Medical-Surgical Telemetry floor. She transferred to Henrico Doctors' Hospital (HDH) where she worked in Critical Care from 1985-1995. During her time at HDH, she worked her way to the top of the clinical ladder as well as worked as a nursing leader on the Post-Surgical Unit. In 1990, she received the HDH Critical Care Nurse of the Year award.

Beth transferred to Johnston-Willis Hospital in 1994 where she worked in an education position as a patient educator and in staff development. When Johnston-Willis and Chippenham merged to form CJW Medical Center, she then focused predominantly on staff development. She was honored by the Virginia Nurses' Association in 1999 as one of "99 Outstanding Virginia Nurses" in the category for education. She began her current position as a Critical Care Clinical Nurse Educator in 2000. In 2002, she completed her Masters in Education with a concentration in Adult Education and Human Resource Development at Virginia Commonwealth University. Beth is a member of the American Association for Critical Care Nurses and earned her Critical Care Registered Nurse certification through this organization.

Beth has received numerous awards and recognitions from CJW Medical Center. In 2003, she received the “Super STAR” employee recognition award. She was also nominated twice for the Frist Humanitarian Award. This award recognizes employees who participate in community service projects. Beth’s nominations came in honor of her missionary and humanitarian work nationally and internationally.

Beth has enjoyed other achievements as well. She speaks at conferences locally and nationally on a wide variety of topics and audiences. These conferences include nursing, Emergency Medical Services (EMS), and leadership topics. In addition to speaking at conferences, Beth maintains her instructor status for Basic Life Support (CPR) and Advanced Cardiac Life Support by teaching numerous sessions of these classes each year for HCA, VCU Medical College of Virginia, and Chesterfield Fire and Emergency Medical Services. She published “Opening a New Unit: A blueprint for success” in *Nursing Management*, a peer reviewed journal, in 2005. She served as a content expert on a 12-Lead ECG interpretation book published by Simon & Schuster Education Group. Beth also worked with Dr. Toth from The Catholic University of America, Washington, DC, to revise and validate a critical care Basic Knowledge Assessment Tool (BKAT), Version 7 that is used nationally to evaluate baseline knowledge for nurses working with critically ill patients.

On a personal note, Beth is married with three children, two of whom still live at home. She actively participates in her church, serving as a deacon and on the contemporary worship planning team. In addition to these activities, she actively participates in local community outreach projects such as CARITAS and The Clinic, both

of which serve homeless and underprivileged people in the community. For fun, and to stay healthy, she teaches a variety of group exercise classes for the Midlothian YMCA and American Family Fitness. She has taught group exercise for over 20 years (and her knees prove it!). She currently holds four certifications in exercise: group exercise; step aerobics; Les Mills BodyPump; and kickboxing.

Upon graduation, Beth will be the only doctorally-prepared nurse at her facility and the first in her family to attain this level of education.